PERCEPTIONS AND EXPERIENCES OF A MULTICULTURAL PERI OPERATIVE NURSING TEAM IN A MIDDLE EASTERN HOSPITAL

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

The researcher has identified in her place of work that the multicultural views and work experience of the staff negatively impacts on optimal team coherence and patient care. Given the pivotal role that teamwork plays in an OR, it is required of the peri-operative (PO) nurses working in a Middle Eastern hospital, to develop a high cultural sensitivity and awareness of each other's values. The goal of the study through the hermeneutic inquiry was to identify the PO participants' meanings of their perceptions and experiences within a multicultural workforce in the OR environment.

A phenomenological interpretative research design was used to illuminate the phenomenon of team coherence and to answer the question, "What are the perceptions and experiences of a multicultural PO nursing team in a Middle Eastern hospital." A purposive sample of n=13 was drawn from a population of 107 PO nurses. A semi-structured interview guide was designed and validated before data collection. Ethical approval and permission to conduct the research was obtained from the Ethics Committee at the Faculty of Health Sciences, University of Stellenbosch and the Institutional Review Board of the Hospital.

The data that emerged from the data analysis was coded and categorized into themes and constitute patterns. The four patterns were multiculturalism within PO nurse teams contributes to complex group dynamics; the pervasive influence of the medical model and power struggle on group cohesion; dominance renders the PO nurses powerless; and empowerment is the panacea to improving team communication. The researcher compiled a written account of the interpretations that emerged from the data analysis and verified it with an external research reviewer. In, addition, member checking was done on two (2) of the participants from the individual interviews to validate the transcribed data.

The Conceptual Theoretical Framework of Habermas on Critical Social Theory and Freire's model of Oppressed Group Behavior supports the findings of the study. The findings suggest that cultural values clarification should change the behavior of the PO nurses and team building activities should enhance group cohesion. Policies on disruptive behavior will create an awareness to illuminate fear and reiterate self-worth. However, empowerment through education, reflection in action and active communication was to liberate powerless PO nurses in a multicultural environment. The pervasive influence of the medical model can be overcome with strong leadership. Furthermore, culturally sensitive leadership might be essential to sustain a supportive and growth producing culture. Further research is recommended.

OPSOMMING

In die navorsers' werksarea het sy geindentifiseer dat die multikultirele uitkyk en werkservaring van die personeel optimale span koheise en pasientsorg negatief beinvloed. Gegee die deurslaggewende rol wat spanwerk in die operasiesaal speel, word dit van die teater verpleegkundiges in n hospitaal in die Midde Ooste verwag om n hoe kulturele sensitiwiteit te kweek. Die doel van die studie, deur hermeneutiese navraag, was om die persepsies en ervaringe van multikulturele PO verpleegkundiges in die operasiesaal te identifiseer.

n Kwalitatiewe benadering met n fenomenologiese interpreterende navorsingsonderwerp was toegepas om die fenomenoom van span kohesie te illumineer deur die vraag te beantwoord, " Wat is die persepsies en ervaringe van 'n multikulturele PO verpleegspan in a hospitaal in die Midde Ooste". n Doelbewuste steekproef van n=13 is geneem vanuit n totale bevolking van 107 teater verpleegkundiges. n Semi-gestruktureerde onderhoudsgids was ontwerp en geldig verklaarg voor die insameling van data. Etiese goedkeuring vir die studie was verkry van die Etiese Komitee van die Fakultiet van Gesondheidswetenskappe, Stellenbosch Universiteit. Goedkeuring om die navorsing te doen, was verkry van die IRB, en toestemming was op skrif geplaas.

Die data wat voortspruit uit die analise, was geenkodeer en gekategoriseer in temas en omvattende patrone. Die vier (4) pattrone was, multikulturalisme dra by tot komplekse groep dinamika te midde van die teater verpleegkundiges; die persewerende invloed van die mediese model en onderlinge struweling op groeps kohesie; dominering veroorsaak weerlose teater verpleegkundiges; en bemagtiging is die redding om komminuksie in die span te bewerkstellig. Die navorser het n geskrewe verslag saamgestel van die weergawe van die data analise en is deur n eksterne navorsingskundige geverifieer. Bykomend is kontrole van lede van twee (2) van die deelnemers vanuit die individuele onderhoude gedoen, om die getransskribeerde data se geldigheid te verklaar.

Die Konseptuele Teoretiese Raamwerk van Habermas se Kritiese Sosiale Teorie en Freire se model van onderdrukte groeps gedrag het die bevinding van hierdie studie gerigsteun. Die bevindinge beveel aan dat kulturele waarde uitklaring gedrag sal verander, en spanbou aktiwiteite groeps kohesie sal bewerkstellig. Die opstel van beleide wat ontwrigte gedrag identifiseer om sodoende 'n bewustheid te kweek wat vrees verminder en selfwaardigheid herstel. Bemagtiging, deur onderrig, refleksie in aksie en aktiewe kommunikasie was as sleutel elemente aangewys om weerlose PO verpleegkunidiges werksaam in die multikulturele omgewing, te bevry. Die aanhoudende invloed van die mediese model kan oorkom word deur sterk leierskap. Voorts mag kulturele sensitiewe leierskap essentiel wees om n ondersteunende, produserende en groeiende kultueer te bewerkstellig. Verdere navorsing word aanbeveel.

DEDICATION

This study is dedicated to my beloved Mother, the late Louise Pitzer, whose faith and prayers were the grace and strength that carries me through the darkest of days.

I will cherish her fond memory until we meet again...

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: SCIENTIFIC FOUNDATION OF THE STUDY

1.1 INTRODUCTION

The effect of the global nursing shortage is evident in all areas of nursing practice, but peri-operative (PO) nursing is experiencing an even greater shortage due to fewer nurses showing an interest in the peri-operative nursing field (Thekdi, Wilson & Yu Xu, 2011:8).

International migration of healthcare workers is a reality world-wide to meet health care needs. Until the beginning of this millennium beginning, the Middle East did not train nurses, primarily due to cultural reasons. Expatriate nurses are recruited to Saudi Arabia to staff the hospitals (Lovering, 2008:37).

The management of a multicultural milieu in the operating room (OR) department of the hospital in which this study took place, is challenging. Diverse and conflicting interpersonal and professional ethical values might result in inadequate patient safety and care, as well as a high staff attrition rate.

1.2 RATIONALE

The researcher has identified in her place of work that the multicultural views and work experience of the staff negatively impacts on optimal team coherence and patient care. International recruitment of nurses may have resolved the problem of acute staffing shortages in Saudi Arabia, but it may also have brought about conflict amongst nurses of the various nationalities and gender (Zakari, Al-Khamis & Hamadi, 2010:297). A perception of superior culture(s) and gender roles against the minority culture(s) and gender roles has emerged and the impact of this on teamwork and patient safety is a growing concern to nurse managers.

In exploring the nature of violence and hostility in the nursing profession, Sheridan-Leos (2008:345), mentions that a common metaphor used in the nursing community to describe mistreatment of nurses by other nurses is “nurses eating their young”. Hostilities and verbal, physical and psychological abuse between nurses has persisted for decades. The terms horizontal violence and lateral violence are often used to describe the abuse. Randle (2003:399) asserts that the concept of lateral violence has been used to describe bullying between colleagues, who are on the

same level within the organization and who, as a result of their perceived low personal self-esteem and poor group identity direct abusive behavior towards each other.

Interpersonal conflict may be linked to negative teamwork and as mentioned by Bigony, Lipke, Lundberg, McGraw, Pagac and Rogers (2009:688), conflict decreases job satisfaction and performance, and results in higher rates of turnover. There is plausible evidence that members of staff may suffer from loss of confidence and poor self-esteem. Corney (2008:165) found a direct relationship between loss of confidence, sleep deprivation and anxiety higher staff turnover among nurses, in relation to interpersonal conflict. Before any recommendation can be made to promote an effective work environment in this context, the perception and experiences of nurses working in the OR in Saudi Arabia needs to be explored.

1.3 SIGNIFICANCE OF THE STUDY

By completing this study an appreciation of the diversity of values in the members of the PO team will be established. Acknowledgement of this diversity and the recognition of the adverse effects of multicultural disparity on patient care may promote, through values clarification at orientation and in-service training opportunities and a better working environment.

The study was unique and significant since it provided the data that will be necessary to enhance efficient and effective teamwork in a multicultural OR environment. The findings obtained from this research should be useful for managing efficient and effective PO nursing teams within a multicultural operating room workforce.

If OR nurses, especially in a multicultural workforce, lack skills needed in teamwork, this poor teamwork might jeopardize patient safety. The researcher has found in her six year clinical experience in Saudi Arabia, that nurses find the demands of OR difficult to adjust and prematurely terminate their contracts. In a Middle Eastern Hospital, where expatriate nurses representing several different nationalities, sign binding contracts, nurses are obliged to stay in this highly stressful environment. The findings might guide the decision making process of all nurses and their managers in the future.

1.4 PROBLEM STATEMENT

A research problem occurs and is significant in nursing when it has the potential to generate or refine relevant knowledge for clinical practice (Burns & Grove, 2007:106).

In the OR in a Middle Eastern Hospital there are complex intertwining relationships and power struggles that take place in this high stress environment which is staffed with people from multicultural backgrounds. According to Costello, Clarke, Gravely, D'Agostino-Rose and Puopolo (2011:115) the influence of hierarchical and imbalanced power relationships can add further stress to the already challenging work environment.

As a result, disruptive behavior is exhibited in the OR, including interpersonal conflict, bullying and lateral violence (Dimarino, 2011:584). Henceforth, these forms of disruptive behavior prohibit effective communication and have a negative effect on the workplace environment. It further affects the quality of patient care, jeopardizes patient safety, and disrupts the effective operation of the health care setting (Guglielmi, 2010:377).

Therefore, due to uncivil behavior and cultural value disparity, teamwork amongst the PO nurses in the OR is disrupted. Hence, in order to ensure patient safety, it is essential that experiences associated with teamwork within a multicultural workforce are explored, examined and addressed.

1.5 RESEARCH QUESTION

A research question refers to a concise interrogative statement developed to direct a study (Burns & Grove, 2007:115). The researcher posed the following question as a guide for this study: ”What are the perceptions and experiences of a multicultural Peri-Operative nursing team in a Middle Eastern Hospital"?

1.6 RESEARCH PURPOSE

The purpose of this study was to describe the perceptions and experiences of a multicultural PO nursing team in a Middle Eastern Hospital.

1.7 RESEARCH OBJECTIVES

The following objectives were set for this study:

- To explore the perceptions and experiences of PO nurses in a multicultural environment.

- To explore interrelationships among staff members.
- To establish leadership styles within this multicultural workforce.

1.8 RESEARCH METHODOLOGY

In this chapter a brief discussion of the methodology is provided. A detailed discussion is provided in Chapter 3.

1.8.1 Research design

The research design was a phenomenological interpretive study, utilizing a qualitative approach, to elicit perceptions and experiences of a multicultural PO nursing team in a Middle Eastern Hospital.

Interpersonal relationships were conceptualized which are embedded in the everyday experiences of the PO nurse.

1.8.2 Population and sampling

A qualitative research approach was utilized. The total population for this study included all the PO nurses (N = 107) working in the OR in the hospital. A purposive sample of thirteen (n=13) participants were individually interviewed.

These participants were purposefully selected in order to cover a complete spectrum of participants of all nationalities and genders working in the study setting.

1.8.3 Specific sampling criteria

The participants were selected to represent all eight nationalities employed in the OR representing gender at the time of the study and who would be at work during August and September 2011.

1.8.4 Ethical considerations

Individual interviews were conducted by two trained fieldworkers in order to optimize participation and sharing of experiences as suggested by the IRB. Both the field workers were trained on the correct handling of the participant information leaflet. Furthermore they were trained on the accurate and truthful gathering of informed, signed consent (Appendix B) from each participant including the participant's permission to have their comments audio recorded. Participants were assured of anonymity, confidentiality and privacy. Permission to conduct this study was obtained from the Human Research Ethics Committee in the Faculty of Health Sciences at University Stellenbosch (Appendix C) and the IRB (Appendix D) at the hospital in the

research setting. All ethical principles were adhered to. Data is being kept locked and stored in the researchers residence and will be transported to South Africa at the end of the researcher's employment contract in Saudi Arabia (March 20th, 2012). Thereafter it will be held in a secure place for five (5) years. Only the researcher will have access to the data. The researcher did not receive specific training in interviewing.

1.8.5 Interview Guide

For the purpose of this study, an interview guide (Appendix A) was developed based on the research objectives, literature and the clinical experience of the researcher. The interview guide was validated by the initial supervisor of this study.

1.8.6 Data collection

Data collection was achieved by means of thirteen (n=13) one-on-one interviews and observation.

On the recommendation of the IRB the researcher did not interview the participants. Two fieldworkers were trained to assist in the gathering of data in order to avoid the participants feeling intimidated. The field workers were one unit manager and one nurse educator. Fieldworker A, is a female South African trained nurse unit manager, originally from Kerla, India. Fieldworker B, is a multi lingual male Saudi Arabian nurse educator with an Australian Master's Degree in Nursing. Both field workers have worked in the hospital for six (6) years respectively. They alternated the roles of interviewer and recorder of field notes. The principal researcher transcribed the interviews.

1.8.7 Validity and trustworthiness

The following principles as described by Lincoln and Guba (1985:290) were applied to ensure trustworthiness.

1.8.7.1 Credibility

Lincoln and Guba (1985:290) refer to credibility as the alternative to internal validity in qualitative methodology. The credibility or the strength of the study was assured by accurately describing and interpreting the perceptions and experiences of the participants. Experts in the field of research methodology were consulted to ensure that the topic was accurately identified and described according to content, research process and outcome.

1.8.7.2 Transferability

The transferability or generalisability of a study to other settings may be challenging in qualitative research (De Vos, Strydom, Fouché & Delport, 2008:346). To meet the criterion of transferability, the theoretical framework was specifically and unambiguously articulated; this ensure that future researchers will understand and utilize the theoretical parameters in alignment with this study. The proposed theoretical framework for this study was based on Habermas' Critical Social Theory and Freire's Model on Oppressed Group Behavior.

1.8.7.3 Dependability

To ensure dependability of the process, which is the equivalent of reliability in the quantitative research paradigm (De Vos et al., 2008:346), two voice recorders were used and two fieldworkers took notes alternatively during the individual interviews. The field workers conducted the interviews according to the interview guide. In addition, De Vos et al., (2008:346) asserts that in the qualitative paradigm dependability relates to attempting to account for changing conditions in the social world that would require adjustments in researching the topic and the setting. Thus, in meeting this aspect of the criterion of dependability, attention will be given to this aspect in Chapter 5.

1.8.7.4 Conformability

According to De Vos et al., (2008:347), conformability or objectivity relates to whether the findings of the study can be verified or confirmed by another researcher/person. Recorded and transcribed data will be discussed and verified with the trained fieldworkers after each individual interview to exclude bias. Transcribed data can also be verified by specific participants to ensure the accuracy of their data.

1.8.8 Pilot testing/Pre testing

The researcher was instructed by the Institutional Review Board (IRB) of the hospital, to employ a field worker to pre test the research instrument and to conduct the one-on-one interviews. The IRB felt that a field worker would ascertain any problems with the instrument without any risk of bias towards the researcher. The pilot study was pre tested by the field worker. One senior nurse, a Filipino national, was interviewed and the data was audio recorded. The data was transcribed verbatim by the researcher. The data was “member checked.” The interview schedule was found to be too long and changes were suggested by the pre test participant.

1.9 DATA ANALYSIS

The analyzing method in this study was through the hermeneutic reference. The data was made available for interpretation by the researcher. The data consisted of the transcriptions of 45-60 minute semi-structured interviews with thirteen participants with operating room experience currently working in this hospital's OR, or until data saturation was reached. Through dialogue, the interviews called forth both the participants' perceptions, experiences and shared understanding. It was from the shared understanding and meaning that interpretation emerged.

1.10 OPERATIONAL DEFINITIONS

Perioperative Nursing: Peri-operative nursing is a combination of individualized and standardized patient care, that is not purely technical, but scientific (Fortunato, 2000:20) and that takes place before, during and after a surgical intervention.

Operating Room Department: In Saudi Arabia this refers to the suite of operating rooms including, the patient holding area, anesthetic induction room, the recovery facility, equipment processing and storage areas. It includes the scrub and the sterile instrument preparation areas and these may be shared with adjoining operating rooms (Schewchuk, 2007:19).

1.11 ACRONYMS USED IN THE STUDY

IRB: Institutional Review Board Saudi Arabia
OR: Operating Room
PO: Peri-Operative

1.12 OUTLINE OF THE STUDY

Chapter 1: Scientific foundations of the study

Chapter 1 portrays the background and motivation for the study. This chapter provides a brief description of the rationale, problem statement, research question, goals and objectives and research methodology, operational definitions and the study layout.

Chapter 2: Literature review

In chapter 2 different literatures are reviewed and discussed and the conceptual theoretical framework of the study explored.

Chapter 3: Research methodology

In chapter 3 the in-depth description of the research methodology applied during this research study is discussed in detail.

Chapter 4: Data Analysis, interpretation and discussion

In chapter 4 the results of the study objectives are revealed, analyzed interpreted and discussed.

Chapter 5: Conclusion & recommendations

In chapter 5 the results according to the study objectives are concluded and recommendations are made based on scientific evidence obtained in the study.

1.13 SUMMARY

International migration of healthcare workers is a reality world-wide (Thekdi et al., 2011:8). Hospital environments remain complex and in Saudi Arabia the healthcare sector rely primarily on international nurse expatriates which lends itself to more complexities (Zakari et al., 2010:297). The management of a multicultural milieu in the operating room (OR) is challenging. Taking the diverse and conflicting interpersonal and professional ethical values into consideration it might lead one to the conclusion that there is inadequate patient safety and care, and a high staff attrition rate (Costello et al., 2011:115).

Developing and maintaining a positive work environment is crucial to ensure that PO nurses feel valued and respected while providing optimal patient care.

1.14 CONCLUSION

In this chapter, the researcher described the rationale for this study, as well as the research goals and objectives. A brief introduction of the research methodology being applied during this research study was presented.

Chapter 2 provides a detailed discussion of the literature review, which assisted in placing this study into context.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, the literature review on multiculturalism and teamwork in the peri operative environment was described. The theoretical and conceptual frameworks that underpin the premise of this study are elaborated.

The peri operative (PO) environment is a high risk and stressful clinical area. The researcher has identified in her place of work that the multicultural views and work experience of the staff negatively impacts on optimal team coherence and patient care. Delivering safe patient care is essential to ensure good surgical outcomes. Thus, effective and efficient team coherence is seen as the foundation to assure quality peri-operative patient care (Daiski, 2004:45).

2.2 SELECTING AND REVIEWING OF LITERATURE

The purpose of this literature review was to acquire a broad and detailed understanding of the current international studies on factors affecting teamwork and the recommendations for managing conflict and patient care risk within a multicultural operating room setting.

According to Burns and Grove (2007:136) and Babbie and Mouton (2005:103), the purpose of a literature study is to bring into light what is currently known regarding a particular topic and to obtain a broad background from authors who have addressed a similar problem. De Vos et al., (2008:262) recommend that in qualitative research, a literature review is conducted after the theoretical framework of an empirical study is determined. Following this, the literature review is organized to support the findings (De Vos et al., 2008:262).

A review of published literature was conducted covering from 2000-2011, relating to keywords; operating room, teamwork, lateral/horizontal violence and multiculturalism. Various databases were explored and journals and text books in the medical and nursing library in the researcher's place of employment in Saudi Arabia. The search engine used was Google and the databases examined were: Medline, CINHAL and the Cochrane library. The researcher did not find any specific literature on the multicultural influence on team nursing originating in the Middle East.

2.3 SOCIETY VIEWS AND THE STATUS OF NURSING: SOCIAL AND ENVIRONMENTAL SETTING OF THE STUDY

Saudi Arabia is an Islamic Kingdom and one of the largest countries in the Middle East (Aldossary, While & Barriball, 2008:125). The Middle Eastern Region includes Oman, United Arab Emirates, Bahrain, Qatar, Syria, Iraq and Kuwait.

The development of healthcare centers has taken place within the framework of Islamic religious beliefs. Hence, Islam remains the center and main aspect that shapes Saudi Arabia (Almalki, Fitzgerald & Clark, 2011:305). Lovering (2008:28) ascertained that the context of nursing in the Middle East is based on the interrelated aspects of Islam and Islamic health beliefs.

According to Lovering (2008:28) the variation in nursing practices between Saudi Arabia and those of western countries, arises from the cultural overlay. International nursing practice moved from scientific or empiricist traditions to the more hermeneutic approaches.

The male is the head of the family and autonomy remains through him (Aldossary et al., 2008:126). The significance of family is considered the most important social unit with its succinct gender roles.

According to Almalki et al., (2008:308) there are several factors that are blamed for the nursing shortage in Saudi Arabia. The poor image of nursing, lack of awareness about the profession and the conflict with the traditional family and personal life is but a few. Lovering (2008:33) concurred with this finding as society views nurses in the Middle East as having a low status and compromised moral standing. The low status relates to low income compared with the job, low academic achievement and ill-defined roles. The high workload, long working duties, night shift and weekends is viewed demeaning in society (Almalki et al., 2008:309).

Lovering (2008:35) postulate that society's lack of respect for nurses and the lack of status of nursing as a profession mean that few are willing to study nursing. In addition families are reluctant to allow their female members to enter nursing as a profession. Many will take nursing as a second choice when they are unable to enter the medical profession due to lower academic achievement.

2.4 FOREIGN EDUCATED NURSES

Internationally, economic disparity contributes to nurse migration to various countries. According to Mitchell (2009:46) most developing countries depend on expatriate nurses to staff its health care industry. Brush and Sochalski (2007:39) stated that factors influences nurses' international movement, can be ascribe as social and environmental. Hence, the Filipino nurses are motivated by the desire to elevate their personal and family status.

Saudi Arabia has an ongoing and evident shortage of professional nurses (Zakari et al., 2010:297). Hence, a large proportion of nursing staff members in the Saudi health care industry are formed by expatriate nurses (Almalki et al., 2011:308).

According to Thekdi et al., (2010:8) the Arab Gulf countries are renown for better work opportunities and higher salaries. Fooladi (2003:33) ascertained that male nurses, in particular, from Jordan and Lebanon seek higher paid positions.

Globally, foreign educated nurses were progressively moved into the nursing workforce, aimed to improve patient safety and quality of nursing care (Yu Xu, 2010:62). Yu Xu (2010:63) postulate that nursing is a regulated profession globally because nursing care directly affects patient health and safety.

Autonomy is detrimental to attain responsibility and accountability in nursing practice. The lack of global nursing education standards impacts the independent role of the nurse and influences the interdisciplinary practice (Newton, Pillay & Higginbottom, 2011:3). Furthermore, the educational requirements for nurses are a mirror of the political and socioeconomic condition of nurses in their country of origin (Bola, Driggers, Dunlap & Ebersole, 2003:40).

Xu Yu (2010:62) ascertain that nurses from diverse educational backgrounds as such, may not perceive themselves as the patient's advocates and coordinators of care. Instead, they are expected to simply carry out physician orders. It appears that nurses from the Philippines, India and China were not exposed to critical thinking and assertiveness skills during their basic nursing education (Yu Xu, 2010:62).

English language proficiency is embedded within safe and competent nursing care. According to Thekdi et al., (2011:10) multicultural nurses experience an inability to assess the sociocultural dimension of language. It plays a significant part in the appropriateness in interactions and affects effectiveness of inter-professional

communications. Professional nurses are required to communicate proficiently within the health care setting and in the operating room. It is thus a necessity for international nurses to acquire culture-and geologically based language nuances to function successfully within any multicultural environment (Yu Xu, 2010:66).

The high dependency on expatriate nurses within the Saudi Arabian health care system remains complex, combining the many different professional groups (Newton et al., 2011:4). According to Zakari et al., (2010:297), these complexities often lead to conflict .

2.5 THE PERI-OPERATIVE ENVIRONMENT

2.5.1 THE OR CULTURE

The OR environment is the area of the hospital that performs a variety of procedures utilizing sophisticated technology. In the typical intense environment such as the OR, teamwork and social hierarchy within the nursing workforce is a necessity. Especially taking the complex inter-professional interactions amongst the multidisciplinary team into consideration.

The message on the OR door indicates that only authorized personnel are allowed. It is not welcoming and creates a feeling of exclusion. Thus, a lack of understanding of the context within an OR environment will lend itself to an atmosphere of intimidation (Gillespie, Wallis & Chaboyer, 2008:261).

Each individual OR is its own complete and full unit of patient care. The area is considered self sufficient, ideally with competent and qualified registered nurses who are able to provide all aspects of care (Shewchuk, 2007:38). Each surgical team requires a circulating nurse, a scrub nurse, a surgeon and an anesthesiologist. Every one of these members has a specific role and function that are dependent and independent (Gillespie et al., 2008:261).

Unrealistic workloads in the peri-operative setting, including call, might contribute to poor patient safety, unfinished tasks and high nursing attrition rates. Work duration, overtime and number of hours worked per week have significant effects on adverse patient outcomes with the likelihood of making an error increasing with longer work hours (Girard, 2003:909). In Saudi Arabia, the inherent job requirement for OR nurses is mirrored in hospitals overseas where “the peri-operative specialty is unique

in that nurses not only consider it normal to work more than 48 hours a week but also are required to take call" (Girard, 2003:909).

Inadequate staff numbers also contribute to burnout syndrome (Mojoyinola & Ajala, 2007:431). Gordon, Llewellyn and James, (2006:632) agreed with this statement as fatigue caused by sleep deprivation is one of the major causes for error in the OR.

2.5.2 EDUCATIONAL DIVERSITY

Attracting nursing professionals to and retaining them, including specialist trained OR nurses, is increasingly difficult worldwide (Thekdi et al., 2011:9). Nursing agencies, who employ hourly/contract nurses of all categories, have flourished in the wake of a nursing supply crisis.

According to Chan, McBey, Basset, O'Donnel and Winter (2004:31) in a study conducted in New South Wales in 2002, the hiring of foreign nurses presents another set of challenges. There are important ethical consequences associated with the migration of nurses to, and from, developing countries. Adverse effects on the quality of health care in developing countries, wage exploitation where foreign nurses are paid less than domestic nurses and the depletion of qualified nurses in their home countries could precipitate a significant global nursing workforce crisis. A study done by Beheri (2009:217) confirmed that inadequate staff numbers exacerbate absenteeism, inefficiency, productivity at work and interpersonal conflict.

The organizational culture influences the level of vigilance by facilitating learning and the redesign of care processes. Overconfidence and complacency amongst experienced health care professionals at the highest levels of organizations, is cited as a significant obstacle to raising the standard of patient safety (Chan et al., 2004:32).

2.5.3 LANGUAGE

Diversity in management initiatives and the lack thereof poses potential problems in language, communication and standards of care. With both public and private facilities being forced to share the shrinking resource pool, effective and attractive retention strategies are recommended. According to Chan et al., (2004:31) areas such as the employment status of nurses, the psychological contract (employee expectations not being met) and the immediate environment in which they practice, must be addressed, if employers are to effectively motivate and retain nurses.

Increasingly in the OR in all South African and Middle Eastern hospitals, hourly paid and/or limited term contract nurses are employed to maintain a hygienic and safe environment, with the goal being a safe procedural outcome for the patient.

2.5.4 RACE

The use of contract nurses may in turn encourage a less cohesive workforce, as cultural differences and social isolation may cause overt and covert conflict. The additional task of orientating contract staff and supervising their standard of practice becomes an extra burden for the full time staff. The increased responsibility to manage contract nurses and to assist junior and less experienced nurses, are grievances often voiced amongst Saudi Arabian staff and is mirrored in the study by Chan et al., (2004:34). The need to employ contract nurses can contribute to lack of continuity of care and the disregard for safe clinical practice (Scribante & Bhagwanjee, 2007:67).

2.5.5 GENDER

According to Fooladi (2003:32) the concept of gender in the Middle East is an interdependent socio-cultural component directly related to religion, socioeconomic status and familial structure. Fooladi (2003:33) further asserts that gender refers to the ways that society regulates human interaction and allocates resources differentially, based on socially constructed norms of masculinity and femininity.

Gender role delineation and segregation within Saudi Arabia kept women away from the public eye and social activities, which explained the lack of Saudi women from nursing (Fooladi, 2003:34). According to Lovering (2008:36) the influx of nurses from Jordan, Egypt and Lebanon migrate to the Arab Gulf countries for better work opportunities and higher salaries. Female nurses placed greater emphasis on the holistic and spiritual aspects of caring. In contrast to male's who appear to be less focused on aspects of compassionate care and views nursing as a source of income and a means to earn a living (Lovering, 2008:37).

Within the Saudi OR working environment, the male nurses of differing Middle Eastern nationalities appear to have greater power and dominance over the female nurses. Male nurses appear to resist accepting a woman in a position of authority (Fooladi, 2003:35), which may becomes a root cause for interpersonal conflict.

2.6 PERI-OPERATIVE NURSE PRACTITIONER

The highly specialized and complex role of the care provided by the peri-operative nurse practitioner can easily be “misunderstood”. The PO nurse is a registered nurse with peri-operative specialist knowledge, skills and attitude, built upon the foundation of a basic nursing programme including sciences and humanities (Alfredsdottir and Bjornsdottir, 2007:30). Coordinated, effective and efficient clinical practices are considered of paramount importance to obtain the best outcome of PO patient care (Shewchuk, 2007:39).

A study done by Shewchuk (2007:39) in Canadian OR’s, the PO nurse is in charge of a single discipline and an expert in both the scrub and circulating roles. The system in Saudi Arabia is similar. The PO nurse is thus responsible for ensuring full compliance with the safe practices and processes in the OR.

Alfredsdottir and Bjornsdottir (2007:30) postulate that the role of circulating nurse includes supervision of patient care throughout the immediate pre operative, intra operative and immediate post operative phase. Directing, leading, supervising and coordinating the activities inside the room is also considered the responsibility of the circulating nurse. The process often occurs in a short time frame, is cyclical, with constant change. Another aspect is considered that of patient advocacy. Critical thinking, continuous astute observation and resulting action is paramount in the OR. Hence, communication amongst PO nurse teams is imperative.

It is thus of utmost importance to minimize medico legal risks and protect the health care facility through a common cultural work ethic of professional conduct (Chadwick, 2010:155).

2.7 PERI-OPERATIVE TEAMS

OR teams are conventionally modeled on multidisciplinary practices (Higgins & McIntosh, 2010:322). It has a diverse system and is multifaceted, which include different cultures, different languages, educational and clinical backgrounds. PO nurse teams are confronted with potential uncertainty inherent in surgical procedures, high-level advanced equipment, brisk transfer of information and labile patient conditions. Contemporary theater practice is bounded by the unblemished synchronization of many small tasks that constitute the procedure (Gillespie, Charboyer, Longbottom & Wallis, 2010:733).

Chadwick (2010:155) stated that peri-operative nurses entering this challenging environment, are prone to face different linguistic, professional and cultural backgrounds. According to Higgins and McIntosh (2010:323) it should be addressed in order to promote a successful transition and to create a culture of safety with team cooperation and adequate communication

Undermining a culture of safety, prohibits effective communication among PO team members and is considered to be the most prominent cause of medical errors (Salas, Rosen & King, 2007:381). Thus, disruptive behaviors have a significant effect on team dynamics that further prohibits communication and can impact patient care and are harmful for PO nurses (Higgins & McIntosh, 2010:323).

2.8 TEAMWORK IN THE OR

According to Gillespie, Wallis and Chaboyer (2008:261) teamwork in the OR is a collective effort of a number of individuals who come together to perform a series of specific tasks. A prerequisite of partnership for teamwork and safe patient outcomes includes respectful, collaborative, and working relationships among the peri-operative nurse workforce (Gillespie et al., 2010:733). In contrast, a task-oriented team, focuses on technical expertise and performance of members with little emphasis on interpersonal behaviors such a good communication, team coordination and leadership (Coe & Could, 2007:610).

Higgins and McIntosh (2010:322) stated that effective interdisciplinary communication is an essential pre-requisite for cohesive teamwork in surgery. The absence thereof leads to devastation in patient safety. The experience of a “sense of belonging” encourages good teamwork. Manser (2009:143) asserts that teamwork is easier to develop if a healthy relationship exists between expatriate and local PO nurses.

Costello et al., (2011:116) ascertain that the concept of team is the blend of the leader’s effectiveness in identifying all the strengths and weaknesses within the department. It is thus imperative that leadership enhance a culture of respect that ensures active listening and effective communication. Implicit hierarchy governs the team interactions and should be clearly structured. The combination of diverse medical cultures and ambiguous nurse team relations, makes effective communication in the OR challenging (Gillespie et al., 2010:734).

The OR environment is considered stressful due to consistent demands resulting from rapid changes, increased public awareness and the psychosocial needs of staff. These competing demands and pressures can lead to disruptive behavior that might render team nursing in the OR negative (Schwartz, Spencer, Wilson & Wood, 2011:737). Within this multifaceted diverse medical and nurse workforce environment, there will always be challenges, due to the increasingly complex and stress-laden OR. It might cause poor interactions to deteriorate further into persistent bullying or lateral violence (Barret et al., 2009:343).

According to Barret, Piatek, Korber and Padula (2009:342) conflict further makes collaboration difficult implicating effective communication and team cohesion. It impacts clinical efficiency, novice socialization and patient safety. Within these collaborative relationships and communicating important health care information, patients can be at risk as their safety in the OR is jeopardized (Costello et al., 2011:116).

2.8.1 COLLABORATION AND TEAM WORK

Team work in different contexts has different meanings and the aspects of teamwork in one context cannot always be transferred as such into another context (Gillespie et al., 2010:735). Thus, knowledge about the methods of fostering teamwork and the positive outcomes of teamwork in the OR context is needed. The quality of team work may also suffer if not all team members are able to participate fully, or if they have different skill levels from different cultural backgrounds. Even though collaboration should be part of team work, the relationships between the concepts, " collaboration and teamwork" remains unclear (Thekdi et al., 2011:8). Setting up teams, while considering the influence of cultural differences, gender roles and behavior, has yet to be rigorously examined and published.

Although there is extensive nursing literature published on how to foster team work, these nursing studies did not specifically look at OR teamwork (Hudson, 2002 in Coe & Gould, 2007: 611).

2.8.2 FACTORS INFLUENCING TEAM WORK

Team work in the OR is vital and has to consist of various members within a team that pull together without individual staff isolating each other (Gillespie et al., 2008:259). It is challenging and this is especially true given the variety of roles or teams within the OR. The OR nurse team in this study setting, comprise of expatriate nurses to staff its patient group.

Gillespie et al., (2008:260) ascertain that the nature of work in an OR has dramatically changed over time. Increased patient morbidity and advancing technology have heavily influenced the job description of PO nurses, and may allude in increase stress and interpersonal conflict. Characteristics of pressure that these nurses might experience are the need to work faster, face high risks, work irregular shifts, handling precision instruments and to master complex techniques which may contribute to interpersonal conflict (Dunn, 2003:977). Nursing practice in the Middle East has been greatly influenced by expatriates who bring along with them different values and beliefs, traditional, socio-political and cultural factors to the workplace environment (Lovering 2008:34). These factors appears to play a strong role in how PO Nurses view their behavior within the OR environment.

In an increasingly diverse world, cultural diversity within the PO environment and amongst the nursing work force, lends itself to learning more about individuals and their cultural backgrounds. Culture has a powerful influence in one's understanding of health and on the individual's interpretation of and response to, health care delivery (Hamlin & Anderson, 2011:291).

The provision of care is and will be greatly influenced by the multicultural nature of the work force and therefore the acknowledgement of the significance of certain cultural beliefs and incorporating these into PO practice, might change the thinking and reaction to the various interpersonal dynamics in the OR.

2.8.3 GENDER INFLUENCES ON PERI OPERATIVE NURSE TEAM WORK

In a diverse, multicultural working environment, the mixture of ethnic group, class and religion may results in a variety of beliefs, pertaining to the behavioral patterns of the health care provider (Thekdi et al., 2011:9). Nurse practitioners have their own cultural beliefs about what is a good nurse and that will appear to affect his or her relation within the group or team. There are major differences in behavior that is dependent on the culture and cultural values and beliefs. These cultural life experiences of males and females determine how they will conduct themselves in the world (Fooladi, 2003:32).

The dimension of cultural values and beliefs is seen as one of the most powerful determinants of health care professionals' behavior (Campinha-Bacote, 2003:8).

Although this review did not find any nursing literature specific to the Middle Eastern nurses and a multicultural work force, the research by Giddings (2005:306) can be rightfully extrapolated to describe the phenomenon observed in the researcher's working environment. Giddings (2005:307) reiterates that nursing remains attached to the ideological construction of the "white good nurse." Her samples of nurses of varying racial, cultural, sexual identity, and specialty backgrounds in the United States, experienced discrimination and unfairness and survived by living in two world. They learned to live in contradiction while working surreptitiously for social justice. This finding underpins Habermas Critical Social Theory as cited by Roberts, DeMarco and Griffin (2009:289), where a dominant culture would marginalize the minority. This theme of oppression and subordination is particularly present for PO Nurses.

According to Sigurdsson (2001:205) PO nursing remained under the direction of the most powerful profession, medicine. It is historically understood and considered to be a female occupation for the purpose to adhere to the medical model. Nursing in general has outgrown the traditional handmaiden image but, it seems as if this image remains with PO nurses (Sigurdsson, 2001:207). This could be attributed to the geographical isolation of the OR. This physical isolation augments their invisibility even further, and makes this environment not understandable for the outside world and others.

For these reasons, nurses, especially female nurses, are familiar with the oppression of themselves as women (Katrinli, Atabay, Gunay & Cangarli, 2010:615).

2.9 INTERPERSONAL CONFLICT

According to Katrinli et al., (2010:616) interpersonal conflict occurs when actual or perceived differences exist or when there is a lack of clarity between two or more parties regarding task accomplishment, ideas, interests or values. If conflict is not resolved, it will escalate and result in reduce productivity, prevent progress and may jeopardize patient care (Embree & White, 2010:167).

According to Hutchinson, Vickers, Jackson and Wilkes (2010:174) the manifestations of disruptive behavior or lateral violence such as the overruling of decisions, undervaluing or belittling of colleagues, withholding of information and sabotage, to name but a few, are evident in the OR. Such inappropriate behavior limits the extent to which individuals can both practice and participate as team members.

These negative feelings, as well as frustration with their powerlessness, lead to internal conflict in the group. The group therefore, is not able to unite to fight against the powerful group and develops a passive-aggressive approach to dealing with the oppressor (Matheson & Bobay, 2007:227).

According to Gillespie et al., (2010:735) disruptive and intimidating behavior may increase the likelihood of errors by nurses. They tend to avoid other disruptive nurses, are hesitant to ask for help and or make suggestions about patient care. Guglielmi (2010:376) ascertains that when nurses are afraid to speak up they use silencing as a coping mechanism. It occurs because they fear being bullied by fellow nurses and physicians and this may lead to patients being harmed. Failure to speak up when risks are known, undermines a culture of safety.

2.9.1 OPPRESSED GROUP BEHAVIOR

Roberts et al., (2009:290) ascertain that within the constraints of the group, devaluation of self-worth and poor self-esteem may develop. Frequently the dominant group selects a number of acceptable roles for the subordinate, which in turn is rejected. According to Matheson and Bobay (2007:228) these members of the oppressed or vulnerable group who attempt to succeed can do so only by attempting to act and look as much as possible like the dominant group, which is often impossible, for example, a change of skin color and gender.

Roberts (2000:74) called these persons "marginal" because they deny their own characteristics yet are not authentic members of the dominant group. The members of the subordinate group attempt to "pass" but they feel shame, self-hatred, and disapproval of their own group. Oppressed nurse’s experience internalized feelings of powerlessness, anger and rage, their manifestation of these feelings can result in behaviors such as gossiping, jealousy, put downs and blaming, thus lateral violence.

Bigony et al., (2009:688) postulates that the behavior displayed by a nurse experiencing lateral violence will include decreased morale, decreased productivity, sabotage, undermining of others activities, withholding information, back stabbing and “scape-goating”. Dimarino (2011:583) further found that failure to respect privacy, broken confidence, threatening and intimidating behavior, humiliation and vulnerability encompasses the disruptive behavior.

Lateral violence may contribute to the increase incidence of errors, low morale, and high turnover among PO nurses (Barrett et al., 2009:343). In addition a nurse

displaying lateral violence will abuse power. The disruptive behavior interferes with effective health care communication and thus threatens a culture of patient safety (Buback, 2004:148-150).

2.10 THEORETICAL ORIENTATION TO THE FACILITATION OF MULTICULTURAL COMMUNICATION

According to Brink et al., (2008:199) a conceptual framework is “a background or information for a study; a less well-developed structure than a theoretical framework. Concepts are related in a logical manner by the researcher.” The framework is an abstract, a reasonable structure of significance, such as a portion of a theory, that guides the progress of the study, is tested in the study, and enables the researcher to connect the findings to nursing’s body of knowledge (Burns & Grove, 2007:540).

Numerous nurse academics have applied the social theorists of critical enquiry in order to promote a culture of “acting communicatively” and to effect change in the functioning of PO nurses within the sociopolitical, economic and cultural forces that influence their nursing practice today (Roberts et al., 2009:290; Mooney & Nolan, 2006:241; Sigurdsson, 2001:200,207).

Freire’s model of oppressed group behavior and Habermas’ critical social theory, is used as a theoretical framework to underpin this study (Roberts, 2000:111).

2.10.1 Freire’s model: Pedagogy of the oppressed

Freire and Habermas believed that social conditions such as the impediment of free, equal and uncoerced participation in society, results in the distortion of the individual's self perception (Roberts, 2000:111). Freire's (cited in Roberts, 2000:72) model of oppression provides a theoretical explanation of the behavior of the "oppressor" and the oppressed group that resembles the phenomenon of the researcher's work milieu. The explanation supports the fact that gender roles and expectations significantly influence the dynamics between the dominant and subordinate structures within the nursing team. Jobs, positions, financial support and privileges are awarded to those in the oppressed group who work to maintain the status quo and who quell any revolt that might arise. Persons who strive for increased status in society are capable and intelligent and are frequently the leaders of the subordinate group. The group therefore has difficulty in establishing a balance of power because its leadership is “marginal". Thus, the oppressed seek approval from the oppressor to be authentic and for a better self-image. Both groups believed that the oppressed have always been inherently inferior and the history of the

development of the hierarchy becomes lost. The system is also maintained by rewarding those in the oppressed group who support the dominant views and values.

2.10.2 Habermas' theory of communicative action

Critical social theory (CST) is a branch of scientific enquiry which describes "distortions and constraints that impede free, equal and uncoerced participation in society" (Sigurdsson, 2001:206). The goal or impetus of CST is to identify and unveil the economic, sociopolitical, and cultural traditions that are believed to shape society.

Habermas' theory of emancipation through group communication, postulates that for peaceful group cohesion, clear communication is imperative. Acting communicatively means that through language and discourse, people either accept or contest each other's statements until they have reached an understanding about the issue. Furthermore, acting communicatively means that social interactions are not guided by unquestioned traditions, but rather these traditions are questioned so people may gain new understanding.

It is the insights from Freire's and Habermas' theories that could enable nursing team members in this study, to recognize the origins of their social conditioning and create an opportunity for embracing diversity and achieving emancipation.

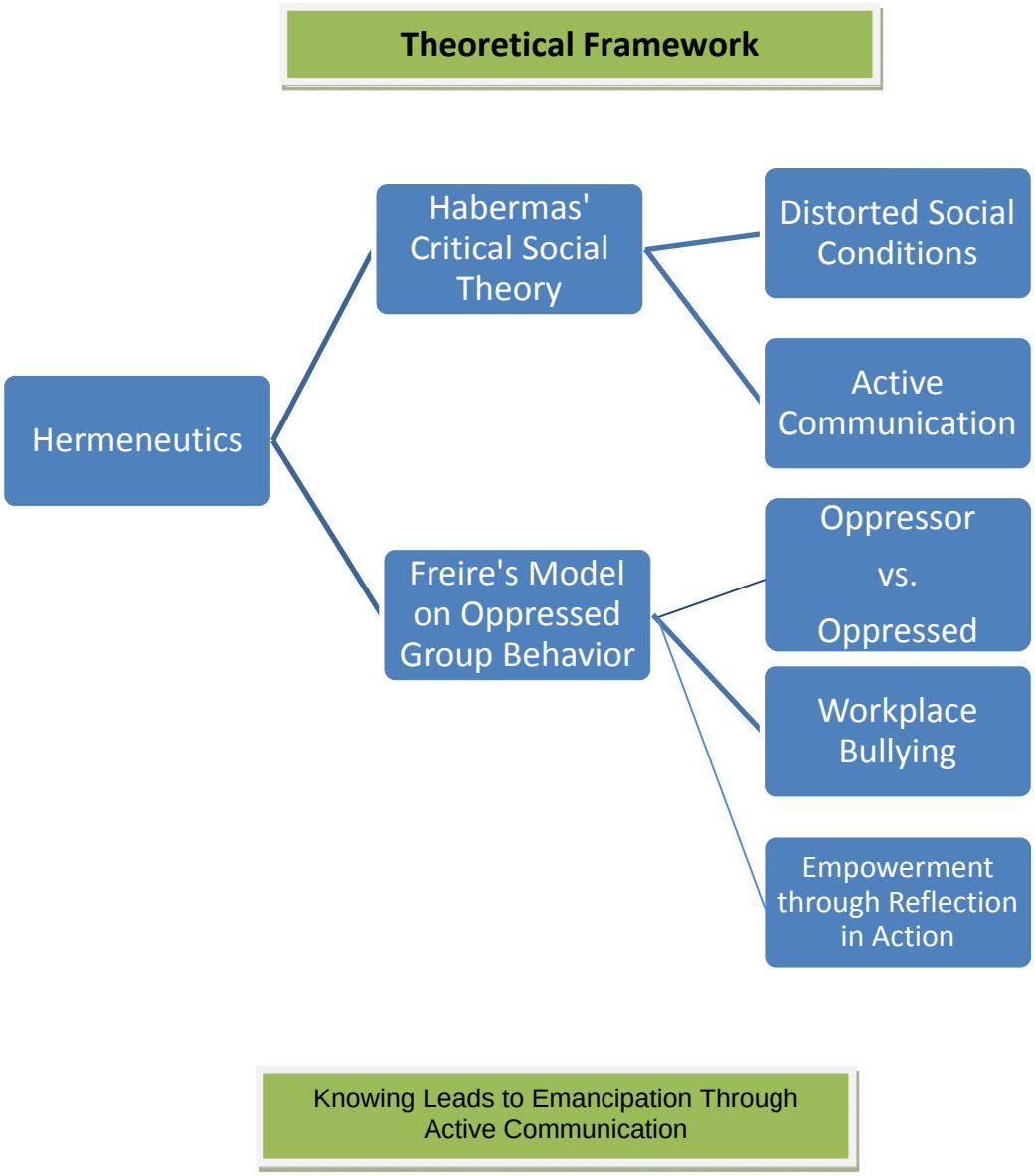

Figure 2.1: Habermas & Freires' Theories on Distorted Social Conditions and Emancipation

2.11 SUMMARY

The literature review conducted has shown that there are many aspects such as the education diversity, cultural disparity, gender, interpersonal conflict, collaboration and teamwork within a multicultural PO nursing team. The global nursing shortage that resulted in the international migration of nurses worldwide might have an affect the teamwork of PO nurses and how they perceive each other in a Middle Eastern Hospital.

Therefore, given the demand of group cohesion to ensure safe patient care, it is important to understand the meaning and understanding of these nurses with regards to group dynamics and their experiences in the workplace.

The conceptual framework provided explains the possible social constraints within the closed off environment and the possibility of oppressed group behavior of PO nurses.

2.12 CONCLUSION

This chapter contains a detailed description of the literature for the study. The conceptual framework provided an explanation on social constraints and oppressed group behavior.

Chapter 3 discusses the research methodology that was used to explore the perceptions and experiences of multicultural PO nurses in a Middle Eastern Hospital.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapters provided a description of the background of the study including a comprehensive literature review regarding the interpersonal experiences within a multicultural team of PO nurses in an OR in Saudi Arabia.

The context of the researcher's study primarily involved the perceptions and experiences of nurses from various nationalities: Saudi Arabia, Jordan, Egypt, Lebanon, Philippines, India, South Africa and Malaysia working in Saudi Arabia.

The purpose of this chapter is to describe the research methodology that was applied to determine the effect of behavior on group dynamics on teamwork in the OR. Included is a discussion of the research design, the research problem, the study population, the sampling procedure, data collection methods, data analysis and limitations of the study.

Research methodology refers to the research plan, in other words, what the researcher did to solve the research problem or to answer the research question (Brink et al., 2008:191). According to Babbie & Mouton (2005:74) the term research methodology is 'a term that simply means the way in which to solve problems'. Thus, this chapter describes the purpose and objectives set for the study, including the research design, the research problem, the study population, the sampling procedure, setting and data collection methods, data analysis and limitations of the study.

3.2 THE GOAL OF THE STUDY

The goal of this study was to describe the perceptions and experiences of a multicultural PO nursing team in a Middle Eastern Hospital.

3.3 OBJECTIVES

The following objectives were set for this study:

- To explore the perceptions and experiences of PO nurses in a multicultural environment.
- To explore the interrelationships among staff members.
- To establish leadership styles within this multicultural workforce.

3.4 RESEARCH QUESTION

A research question refers to a concise interrogative statement developed to direct a study (Burns & Grove, 2007:115). The researcher posed the following question as a guide for this study: ”What are the perceptions and experiences of a multicultural Peri-Operative nursing team in a Middle Eastern Hospital"?

3.5 RESEARCH METHODOLOGY

3.5.1 Research approach and design

According to Burns and Grove (2007:553) the research design is a 'blueprint' for conducting a study and guides the planning and implementation of a study in a way that is most likely to achieve the intended goal. The study entailed a qualitative approach, and aimed to uncover meaning and significance of the PO nurses from within a multicultural OR environment. The phenomenological design allowed the researcher ways of collecting information, whilst preserving spontaneity of the participants' perceptions and experiences (Jacobs, Kehoe, Matarese & Chinn, 2005:6).

Phenomenology has its disciplinary roots in both philosophy and psychology (Polit & Beck, 2006:212-215). It is concerned with the lived experienced of people as a tool for better understanding the social, cultural, political and historical context in which these experiences occur. In a phenomenological study the main data source is the in-depth conversation that takes place between the researcher and the participants (Polit & Beck, 2006:215). A phenomenon is something that is known to us and experienced though our senses, something that impresses the observer as extraordinary (Burns & Grove, 2007:167).

The underlying research paradigm lied within the interpretivist perspective. According to Heidegger as cited in Corney (2008:168), the interpretive process is circular and is referred to as hermeneutic inquiry. Applied in the study, hermeneutic (interpretive) phenomenology was concerned with interpretation of the structures of experience and with how things were understood by the PO nurses who lived through these experiences (Wojnar & Swanson, 2007:173).

From an interpretivist paradigm, the researcher interacted closely with the participants to gain insight and formed a clear understanding as to what PO nurses perceived were the effects of a multicultural workforce on teamwork.

The study attempted to make sense of the participants' life-worlds by interacted with them, appreciating and clarifying the meanings they ascribed to their experiences. Throughout the research process, the researcher used a phenomelogical, hermeneutic interpretative approach to answer the essence and meaning of a multicultural workforce and how it affected the teamwork in the OR.

Therefore, the researcher aimed to gain a deeper understanding of the essence and meaning of the OR Nurses' views on their self perception, to describe and explore their relationships with others and their behavioral patterns within the multicultural workforce. Their possible perception of oppression and abuse amongst each other was explored. The phenomena of behavior, ethnocentrism and gender roles in a multicultural team was described before patterns influencing and affecting group cohesion and dynamics, and the relationship of leadership could be understood.

The application of this approach with regards to this study allowed the researcher to listen to the in-depth interviews of the participants that lasted around 45 to 60 minutes. In this study participants were quoted verbatim, that is word for word in the transcriptions as this assisted to authenticate the data collected. Thereafter the researcher read and reread the transcriptions. The researcher was therefore able to grasp the lived experiences of the participants working within the multicultural PO nurses.

3.5.2 The role of the researcher

Heidegger as cited in Corney (2008:168) proposed that all knowledge emanates from people who are already in the world and seeking to understand other people who are in the same world. According to his phenomenology, Heidegger allowed the active and purposeful use of the researcher as an individual, not just as a means but as an integral part of the study (Corney, 2008:168). Heidegger postulates that language as what opens access to meanings and is the central focus of his philosophy. He ascertains that language is seen as the condition of the human world being disclosed.

Crist and Tanner (2003:203) argued that when using a hermeneutic interpretive phenomenological approach, it is not required of the researcher to bracket preconceptions or theories during the process. Instead, the research process included the significance of the existing world and its meanings for the researcher, the supervisor, the external reviewer and the key study participants. They acknowledged any assumptions that could both influence the researcher's conduct of transcribing the interviews and observations, as well as the whole teams' interpretations.

According to Corney (2008:168) the researcher being within the study setting, had a preliminary understanding of the human action, and therefore brought personal experience and understanding to the research.

3.5.3 Population and sampling

The population according to Burns and Grove (2007:549) are all elements that meet the sample criteria for inclusion in a study and can also be referred to as a target population. According to De Vos et al., (2008:193) the "Population is a term that sets boundaries on the study units."

The target population for this study was perioperative nurses in an Operating Room Department in a hospital in Saudi Arabia. The selected hospital was chosen since the researcher is employed at the Hospital, as the Nurse Manager in the Operating Room Department, consequently the information required for the population and sampling was easily accessible.

In order to create homogeneity, only nurses who were OR trained or experienced were included in the study.

Access to the target population was obtained once ethical approval and IRB approval had been obtained. Therefore, the total population that the researcher wishes to gain information from included all the PO nurses (N = 107) working in the OR in the hospital in Saudi Arabia. However, because a qualitative research approach was utilized large numbers of participants were not required.

Participants of different genders and nationalities were included;

Table 3.1: Nationalities and Gender of target population

Nationality	Females	Males
Egyptians	4	12
Filipinos	14	3
Indians	10	1
Jordanians	4	20
Lebanese	3	22
Malaysians	4	0
Saudi Arabians	1	0
South Africans	9	0
Total	49	58

De Vos et al., (2008:82) defined a sample is a small part or fraction of a whole, selected by the researcher to participate in a research study. Sampling according to Burns and Grove (2007:554) is a "process of selecting a group of people, events, behaviors, or other elements that are representative of the population being studied." Sampling in this qualitative research study was flexible and continuous until no new themes emerge from the data collection process, and until data saturation was reached.

According to De Vos et al., (2008:270) in qualitative research a maximum of ten participants are required or until data saturation is reached. De Vos et al., (2008:294), stated that there are two criteria to determine if the sample size is 'enough'. The first is 'sufficiency', meaning there are sufficient numbers to reflect the range of participants so that others outside the sample may be able to connect with those in the study. The second criterion is related to the saturation of information obtained, in other words, the researcher begins to hear the same information repeatedly and no longer learns anything new.

For the purpose of this study, a purposive sample of thirteen (13) participants from the PO nurses with certain characteristics and holders of data needed for the study was drawn upon to obtain there meanings and understanding regarding team cohesion in the OR. The PO nurses were all registered nurses, males and females, representing all nationalities. Data saturation was obtained after the thirteenth interview.

These participants were purposefully selected in order to cover a complete spectrum of participants of all nationalities and genders. According to Burns and Grove (2007:337) in non-probability sampling, not every element of the population has an opportunity for selection in the sample. Purposive sampling is sometimes referred to as 'selective sampling'; the researcher consciously selects certain subjects, elements, events, or incidents to include in the study (Burns & Grove, 2007: 344).

3.5.4 Interview Guide

The instrumentation for this study consisted of a semi-structured interview guide (Appendix A) and one on one interviews.

An interview stated by Burns and Grove (2007:544) is a structured or unstructured oral communication between the researcher and the subject, during which information is obtained for a study. Since the researcher is the OR Manager at the

particularly hospital, one trained fieldworker did the interviews with the participants, while a second fieldworker took notes during the interviews, as indicated by the IRB of the hospital. They alternated their roles of interviewer and field note recorder.

The questions in the guide was designed to establish what the PO nurses' perceptions and experiences were of working within a multicultural department.

The interview guide consisted of the following section that also represents the study objectives:

- To explore the perceptions and experiences of PO nurses in a multicultural environment.
- To explore interrelationships among staff members.
- To establish leadership styles within this multicultural workforce.

The first objective, the experiences of PO nurses within a multicultural environment were to uncover the interpersonal relationships embedded in their everyday interaction among the various nationalities. The second objective was to obtain their meanings and understanding regarding behavior, ethnocentrism and gender roles in a multicultural team to be able to identify significant patterns influencing and affecting group cohesion and dynamics. The third objective was to obtain their understanding of the impact of leadership on team cohesion.

Therefore the semi-structured interview guide did not consist of any direct question, such as,

> "Do you experience workplace bullying?", since yes and no type of answers were avoided.

3.5.5 Pilot study (pretesting)

A Pilot-testing, also referred to as pretesting in qualitative research, is completed to examine the reliability, validity and usability of the measurement methods in a target population (Burns and Grove, 2007:298). According to De Vos et al., (2008:206) the pretesting of a measuring instrument consists of "trying it out on a small number of persons having characteristics similar to those of the target of the respondents".

De Vos et al., (2008:206) ascertain that it is important to conduct a pilot study in qualitative research and that the pre-testing allows for modification of the interview process.

Adhering to the recommendation of the IRB, the pretest was conducted by a fieldworker who ascertained any problems with the interview guide without any risk of bias towards the researcher. The pretest was conducted on one (1) participant of the population. She was a senior nurse, a Filipino national, who was not included in the study. The test was to establish the feasibility of the data collection process, including the effectiveness of this method data collection specifically with PO nurses within a multicultural workforce; their willingness to participate; and the timescale required to perform the interviews.

According to Burns and Grove (2007:244), even with the most carefully planned interview, there is always the possibility of an error. The interview guide was found to be too long and the schedule was adjusted afterward to fit the objectives more specifically.

3.5.6 Validity/authenticity testing of the research

In order to establish the validity of the research, it is necessary to determine, firstly, the extent to which conclusions effectively represent empirical reality and then secondly, to assess whether the constructs devised by the researcher represent or measure the categories of human experience that occur (Brink et al., 2008:118). In qualitative research trustworthiness of data is evaluated, specifically the criteria of credibility, dependability, conformity and transferability. For the purpose of this study, the criteria as described by Lincoln and Guba (1985:290) follow.

3.5.6.1 Credibility

Credibility refers to whether the inquiry was conducted in such a manner so as to ensure that data gathered, emerging themes and findings (Polit & Beck, 2006:435). A qualitative study is credible when it presents such accurate descriptions of human experience that people who also share that experience would immediately recognize the descriptions. Therefore the researcher completed a literature review using the most relevant and reliable sources of literature ref (Burns & Grove, 2007:135).

Experts in the field of teamwork and PO practice, nursing and research methodology were consulted to determine feasibility and content of this study, to evaluate the research process and outcome. Brink et al., (2008:199) asserted that "since from this perspective, the purpose of qualitative research is to describe or understand the phenomena of interest from the participants' eyes. The participants are the only ones who can legitimately judge the credibility of the results". Internal validity/truth-value or credibility was assured by being satisfied that the participants accurately understood

the questions and agreed to the accuracy of the transcribed data. In addition member checking was done on two (2) key study participants from the individual interviews, to validate the transcribed data.

3.5.6.2 Transferability

Transferability, also called generalisability, is concerned with the applicability of one set of findings to another context, for example, to other populations, settings and treatment arrangements. The transferability of the findings of a qualitative study tends to be problematic. In order to acquire a sense of transferability, the researcher should strive to incorporate the concepts and models contained in the theoretical framework during data collection and analysis processes.

To further enhance the possibility of transferability, the researcher should indicate whether information from various sources of data gathering was used. This is known as data triangulation (De Vos et al., 2008:346). However, in the current study the only method of data gathering used was one on one interviews. Hence, the conclusion was made that the findings of the study may not be generalisable.

3.5.6.3 Dependability

Establishing dependability in a study requires an audit. To facilitate dependability an enquire assessor, usually a peer, will follow the development and procedures used by the researcher in the study and establish whether they are acceptable, in other words, dependable and trustworthy (Brink et al., 2008:119).

In this study the researcher verified the transcribed data recorded during the interview with the fieldworker. The researcher and the fieldworker discussed the transcripts and clarified differences of opinions to ensure that the interpretation of the transcripts was congruent with the recorded interview.

The data was verified for authenticity and accuracy and confirmed that it was the actual data as recorded during the interview. The analysis of the data, the codes, the subsequent themes and constitute patterns were verified by the supervisor of the researcher, the researcher and the external reviewer. The supervisor and external reviewer reaffirmed that the codes, themes and constitute patterns should adhere and be linked to the conceptual framework of the study. In most cases the supervisor and external reviewer were in agreement with the themes and constitute patterns that were identified by the researcher.

3.5.6.4 Conformability

Conformability guarantees that the findings, conclusions and recommendations are supported by the information obtained and that there is an integral agreement between that investigator's interpretation and the authentic data (Brink et al., 2008:119). An audit procedure was completed by the supervisor of the study and the external reviewer who confirmed that an integral agreement exists between the researcher's understanding and the real evidence.

The audit procedure was undertaken by the supervisor of the researcher and the external reviewer who checked whether the transcripts resembled the raw data on the voice recordings and that the recordings were transcribed verbatim. Furthermore, the continuation and resemblance between the themes and constitute patterns were checked by the supervisor of the study and external reviewer. Where the supervisor and external reviewer were not in agreement with the codes, themes and constitute patterns derived by the researcher, all of them read through the transcripts again until all were in agreement with the regard to the various themes and patterns.

Member checking was also done. Member checking refers to showing the final product of the analysis to the participants (De Vos et al., 2008:346). Hence, two key participants in this study were given an opportunity to view the findings and make further recommendations. However, further recommendations were not made.

3.5.7 Data collection

Data collection according to Burns and Grove (2007:41) is the identification of subjects and the systematic gathering of information applicable to the research purpose or the exact objectives, questions or hypotheses of the study. In addition, the procedure of collecting data is extremely important to determine the success of the study.

Two fieldworkers alternatively conducted the interviews or recorded the field notes. Fieldworker A is a female nurse manager working in the multicultural hospital environment and is a South African trained nurse originally from Kerla, India. Fieldworker B is a Saudi Arabian male nurse educator with an Australian Master’s Degree in Nursing. He is also a translator of different languages. Both fieldworkers received training on how to conduct an interview from the hospitals' director of nursing education who has completed two previous qualitative research studies.

The participants gave written consent to the interview and the written and electronic recording of the discussion to capture the data for subsequent verbatim transcription. A sound check was done prior to the interview to ensure the voice recorder is switched on therefore measures were taken to ensure that all data was captured accurately. A back up recording device was available.

The voice recorded interviews as a method of data collection, allowed the maximum flow of information and accurate recording of the data. It further enabled the researcher to return again and again to the 'raw' data (Corney, 2008:168).

The interviews were conducted in the OR's conference room which is a quiet, private and undisturbed location. A sign on the door stated that an interview was in progress. All telephone calls were diverted and the fieldworkers made every effort possible to avoid all disturbances.

The interview began with an open ended question. Prompt words/phraces were included in the guide to obtain more information and further meaning in some areas, but caution were taken to avoid biasing the participants' responses

After the interview the fieldworkers summarized the notes, as confirmation to the participants that the fieldworkers understood them perfectly well.

Simple English language was used to ensure that all participants understood the questions. Some participants answered in Arabic, Tugaloo, Hindi and Malayalam as they were more comfortable in expressing themselves in their home language.

The duration of each individual interview was between 45-60 minutes. Thirteen (13) individual participants were interviewed over a period of six weeks. The six week data collection period was due to the availability of the participants and field workers. Their work commitments, hours and personal obligations prevented their immediate availability.

De Vos et al., (2008:281) recommends that at the beginning of each interview the participant should be made to feel comfortable and that the questions should be open- ended in nature. According to De Vos et al., (2008:288) the researcher can hand the interview schedule to the participant so that they can read it together. Furthermore, the participant could choose which particular question he wished to answer at specific stages. Therefore, each interview followed a relatively similar pattern. In addition, the fieldworkers handed the interview schedule to the

participants to go through before starting the interview. Once the participants were at ease, the fieldworkers started the interview. The question and prompt words focused on the broader concept of the effect of a multicultural workforce in the OR environment.

The researcher should monitor that the scheduled questions contained in the semi-structured interview guide be covered. To maintain data quality, according to Burns and Grove (2007:447), the selection of the participants and the collecting of the data should be implemented in a consistent manner. However, data collection in a qualitative study is not as tightly controlled as in a quantitative study (Burns & Grove, 2007:451).

3.5.8 Data analysis and interpretation

Burns and Grove (2007:536) describe data analysis as a technique used to reduce, organize, and give meaning to data. According to Brink et al., (2008:119), data analysis in qualitative research is concerned with the analysis of written words, videotapes or audiotapes. Interpretive analysis can be seen as a back and for the movement between the strange and the familiar, as well as between a number of other dimensions. Data analysis involves reading through the data through the data repeatedly and engaging in activities of breaking down the data into categories and to identify possible themes and constitute patterns.

In this study qualitative data analysis was based on an interpretive philosophy. The researcher examined meaningful and symbolic content by analyzing the OR Nurses' perceptions, attitudes, understanding, knowledge, values, feelings and experiences to approximate their construction of the phenomenon.

The transcription of the interviews was done by the researcher. Most of the transcriptions of the interviews were done on the same day as the particular interview took place. In cases where this was not possible it was done within 72 hours of recording. In this manner the researcher became familiar with the data as it was gathered, by reading and re-reading it to ensure accuracy.

The recordings were transcribed and significant statements pertaining directly to the phenomena were extracted (Corney, 2008:168). It was written out by hand and cut up into single phrases. Any repetition was eliminated. Each significant statement was then considered to formulate meanings without seeing connections with the original transcripts. The aggregate formulated meanings were then clustered into themes. To

validate these themes, they were referred back to the research question, to ascertain whether anything in the research question was not accounted for in the cluster of themes, and whether the themes proposed anything unplanned in the originals.

The goal of data analysis is to identify persistent words, phrases and themes that could be grouped into categories. Based on the Heideggerian beliefs, the researcher applied the seven stage process for interpretive analysis devised by Diekelmann, Allen and Tanner (Gillespie-Johnson, 2008:176). The use of this systemic seven step strategy for interpretation allowed for any contradictions and inconsistencies, similarities and differences across texts to be observed as the hermeneutic analysis proceeded. Hermeneutic inquiry almost always focuses on meaning and interpretation, how socially and historically conditioned individuals interpret the world within their given context.

Diekelmann, Allen and Tanners' seven stage strategy for data interpretation:

1. The researcher reads through all of the transcripts to get a sense of the whole and jots down ideas as they come to mind.
2. Writing interpretive summaries and coding for emerging themes
3. Analyzing selected transcripts as a group to identify themes
4. Returning to the text and to the participants to clarify disagreements in interpretation and writing a composite analysis for each text.
5. The transcripts were compared and contrasted to identify and describe shared practices and common meanings.
6. The themes were linked to enable the researcher to identify the pattern.
7. Responses made by the researcher, supervisor, external reviewer and key study participants were elicited and any further suggestions were taken into consideration.

3.5.8.1 Reading the interviews to obtain an overall understanding

All the transcripts, as an entire set, were examined by the researcher, the supervisor of the study and an external reviewer. The external reviewer was a South African PhD graduate, contracted to the Nursing College at the hospital where the study took place. She was familiar with hermeneutic interpretation. The first level of analysis consisted of summarizing participant experiences with the intent of understanding the interviews as a whole with inclusion of the context.

The initial discussion guided the inquiry. Several lines from the transcripts lead to a second interview with some of the participants, and deeper and richer understanding were provided.

The transcripts were carefully and thoroughly read and re-read line by line, to enable the researcher to summarize the participant's stories.

Field notes made by the field workers, and the detailed voice recordings were discussed immediately after each interview with the researcher. Participant observations and the researchers ongoing thought process, feelings, and emotional reflections were also recorded as part of the data analysis. As suggested by Corney (2008:168) all these data sources were used in conjunction with the interview transcript and provided the basis for establishing the credibility of the data interpretation.

Significant statements and concepts were highlighted; coded and further exploration was discussed with the supervisor and external reviewer. According to Polit and Beck (2006:245) coding is a process for categorizing qualitative data. The inclusive qualitative analyzing method involved transcribing the interview transcripts, coding the data into themes, and drawing conclusions regarding the phenomena based on these themes (Gillespie-Johnson, 2008:176).

3.5 8.2 Writing interpretive summaries and coding for emerging themes

During this phase, central concerns, key paragraphs, phrases and words were extracted from the transcripts to exemplify the message of each participant. Meanings which unfolded and affected the participants shaped the current experiences presented to the researcher and the supervisor. Relationships of the participants earlier and current experiences were explored (Crist & Tanner, 2003: 205). Throughout the interpretive process, summaries were written and re-written until interpretations emerged. The researcher asked the supervisor and external reviewer to review these summaries for central concerns and to extract exemplars to characterize the most common themes. The writing of interpretations and summaries continued with all the participant transcripts until final themes emerged.

3.5 8.3 Analyzing selected transcripts as a group to identify themes

During the third level of analysis, key phrases identified by the researcher and supervisor were compared across interviews. As the central concerns became clear, shared meanings were observed. It was verified with the external reviewer. The key

phrases were grouped together according to context and became central concerns. Frequently, the researcher and the supervisor agreed on the meaning in the data.

When there were differences in interpretation, the original transcribed interview were checked, which had a full description of the situation. This process assisted in reaching consensus.

The researcher sought related research findings in the literature to support or refute notions found in the texts.

3.5 7.4 Returning to the text and to the participants to clarify disagreements interpretation and writing a composite analysis for each text

The fourth level involved indentifying similar and contradictory categories within texts and across texts and comparing them again to the literature to identify related findings.

3.5 7.5 Transcripts were compared and contrasted to identify and describe shared practices and common meanings

During the fifth level of analysis, the entire data set was examined for common patterns constitute of interpersonal relations and group dynamic within the multicultural PO environment.

3.5.7.6 The themes were linked to enable the researcher to identify the pattern

Level six involved a further review of the interpretation from key study participants. The external reviewer reviewed the interpretation in this phase and evaluated whether the themes seemed appropriate and whether the significant data was presented to represent the themes. Two participants from the study were willing and available to review the findings; these participants were asked to evaluate whether the interpretations were true for them and if the examples were exemplary of PO team nursing within the multicultural environment.

3.5.7.7 Responses made by the researcher, supervisor, external reviewer and key study participants were elicit and any further suggestions were taken into consideration

The multiple steps of analysis conducted with the other researchers and participants helped ensured that data were not over interpreted or under interpreted.

3.5.7.8 Interpretation and checking

The use of this systemic seven step strategy for interpretation allowed for any contradictions and inconsistencies, similarities and differences across texts to be observed as the hermeneutic analysis proceeded (Wojnar & Swanson, 2007:173).

According to Burns and Grove (2007:552) interpretation involves explaining the meaning of information. It was further stated that the process of interpretation includes examining evidence, determine findings, forming conclusions, exploring the significance of the findings, generalizing the findings, considering the implications, and suggesting further studies.

All transcribed recorded interviews were coded and analyzed immediately to get the reply for the next interview and show the quality of data. Then final themes with exemplars from interviews were determined and verified by the supervisor of the study and the external reviewer.

The researcher compiled a written account of the interpretations that emerged from the data analysis and verified this with fieldworkers.

In this study participants were quoted verbatim as this added to the 'richness' of the study as noted in De Vos et al., (2008:298).

3.5.8 Ethical considerations

According to Polit and Beck (2006:87), the three primary principles that are articulated in the Belmont Report constitute a standard for the ethical conduct of research. These three principles are: beneficence, respect for human dignity, and justice. A Discussion of each of these three principles follows.

3.5.8.1 BENEFICENCE

No degree of harm was generated by this study because the data collection process consisted only of interviewing the participants. None of the questions alluded to any matter that might induce negative emotions or psychological trauma. Thus, the principle of beneficence imposed a duty to the researcher to minimize risks and to maximize benefits, both for the participant and for the community as a whole (Polit & Beck, 2006:170).

3.5.8.2 RESPECT FOR HUMAN DIGNITY

Respect for human dignity includes the right to self-determination and the right of the participant to full disclosure of the facts (Polit & Beck, 2006:88). Self-determination in this context means that all the participants who participated in the study have an absolute right to decide whether they want to participate or not, without the possibility of them being penalized or disadvantaged in any way whatsoever if they not to participate (Polit & Beck, 2006:89).

The participation was voluntary. Informed written consent was obtained. The participants were informed that they had the right to withdraw from the study at any time and without providing an explanation or justification. The written informed consent (Appendix B) form therefore supplied the participants with the following information; any potential harm that might be associated with the research, the benefits associated with the study, and the right of participants to withdraw from the study at any time whatsoever.

Permission to conduct this study was obtained from the Human Research Ethics Committee in the Faculty of Health Sciences at University Stellenbosch (Appendix C) and the IRB (Appendix D) at the hospital in the research setting.

3.5.8.3 JUSTICE

Polit and Beck (2006:90) described justice as an inalienable right that the participant has to fair treatment and that the information that they impart for the purpose of research needs to be kept completely private and confidential.

Anonymity, according to Brink et al., (2008:45), means namelessness and refers to the researcher's efforts of maintaining secrecy surrounding the identity of the participants in this study. However, absolute anonymity of the data of the individual interviews was not possible. Nevertheless, the researcher processed the data anonymously (Brink, 2008:46). In this study an identification number was assigned to each participant and the respective voice recording of each of the interviews. Therefore the researcher can conclude that the data had been processed anonymously.

According to Brink et al., (2008:45-46), a participant who agrees to participate in research has a right to expect that the information collected from or about him/her will remain private.

Therefore, the participants were assured that any information divulged would not in any way be connected to them personally when feedback and recommendations were given to the IRB and hospital management of the hospital.

Data is being kept locked and stored in the researchers residence and will be transported to South Africa at the end of the researcher's employment contract in Saudi Arabia (March 20th, 2012). Thereafter it will be held in a secure place for five (5) years. Only the researcher will have access to the data.

Individual interviews were conducted by trained fieldworkers in order to optimize participation and sharing of experiences as suggested by the IRB. Both the fieldworkers were trained on the correct handling of the Participant Information Leaflet. Furthermore they were trained on the accurate and truthful gathering of informed signed consent (Appendix B) from each participant including the participant's permission to have their comments audio recorded.

The researcher did not receive specific training in interviewing.

3.6 SUMMARY

According to Polit and Beck (2006:245) the philosophical orientation of qualitative research is holistic, and the purpose of this research is to examine the whole rather than the parts. Burns and Grove (2007:331) stated further that qualitative researchers are more interested in understanding complex phenomena than in determining cause-and-effect relationships among specific variables The experience and perceptions of PO nurses on teamwork in a multicultural OR environment were explored by asking open-ended questions. During the interviews the participants had the opportunity to express their feelings regarding the group dynamics and behavior of PO nurses in the OR.

3.7 CONCLUSION

This chapter contains a detailed description of the purpose and objectives of the study. The design of the study was explained as well as the population and sampling processes. Validity testing of the research was also explained in this chapter. Information regarding the ethical principles maintained and data collection and analysis were also included.

Chapter 4 will present an in-depth description of data analysis and interpretation of the research findings.

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The findings of the study will be presented and discussed in the current chapter. Hence the researcher reflects the meaning and understanding of the PO nurses with regards to factors influencing group cohesion in a PO environment in a Middle Eastern hospital as obtained during the interviews.

The raw data was transcribed verbatim, that is word for word to authenticate the trustworthiness of the data collected. Inductive reasoning was applied to build the themes from the bottom up. Inductive reasoning concerns the empirical collection of facts and drawing conclusions from these facts (Burns & Grove, 2007:16-17). The word empirical means experience gained through using your senses (Burns & Grove, 2007:539).

The analyzing method in this study was a hermeneutic approach. The data was made available for interpretation of perceptions and experiences of the PO nurses and consisted of the transcriptions of 45-60 minute semi-structured interviews with thirteen participants with operating room experience. Through dialogue, the interviews called forth both the participants' perceptions and experiences and shared understanding. It was from the shared understanding and meaning that interpretation emerged.

Based on the Heideggerian beliefs, the researcher applied the seven stage process for interpretive analysis devised by Diekelmann, Allen and Tanner (Gillespie-Johnson, 2008:176). The use of this systemic seven step strategy for interpretation allowed for any contradictions and inconsistencies, similarities and differences across texts to be observed as the hermeneutic analysis proceeded.

The data will be presented in two sections. Section A explains the biographical data that arose at the onset of each interview whilst Section B will focus on the codes and themes that emerged from each interview. In Section B from each theme, constitute patterns were drawn from the overall interpretation. To ensure privacy of the participants each participant was assigned a number.

4.2 SECTION A: BIOGRAPHICAL DATA

4.2.1 Age range of the PO nursing staff

The ages of the participants ranged between 25 to 59 years. One participant was 59 years old. The majority (n=8) of the participants were in the age group between 25 to 34 years and four participants were between 35 to 44 years of age.

4.2.2 Gender

Out of the thirteen participants, seven were males and six were females. This could be explained due to the majority of the PO nurses in the OR were made up of male nurses.

4.2.3 Years of experience in PO nursing

Collectively the participants had 67 years of PO nursing experience. The length of employment of participants varied from two to ten years with the hospital in the Middle East. Corney (2008:208) has found that age does exert an influence on teamwork and more especially older employees tend to experience higher levels of job satisfaction.

4.2.4 Highest qualifications in the PO nursing

Seven participants were in possession of a diploma in PO nursing which is a twelve month programme and five participants completed a certificate course which is a six month programme.

Histogram of nationalities and gender

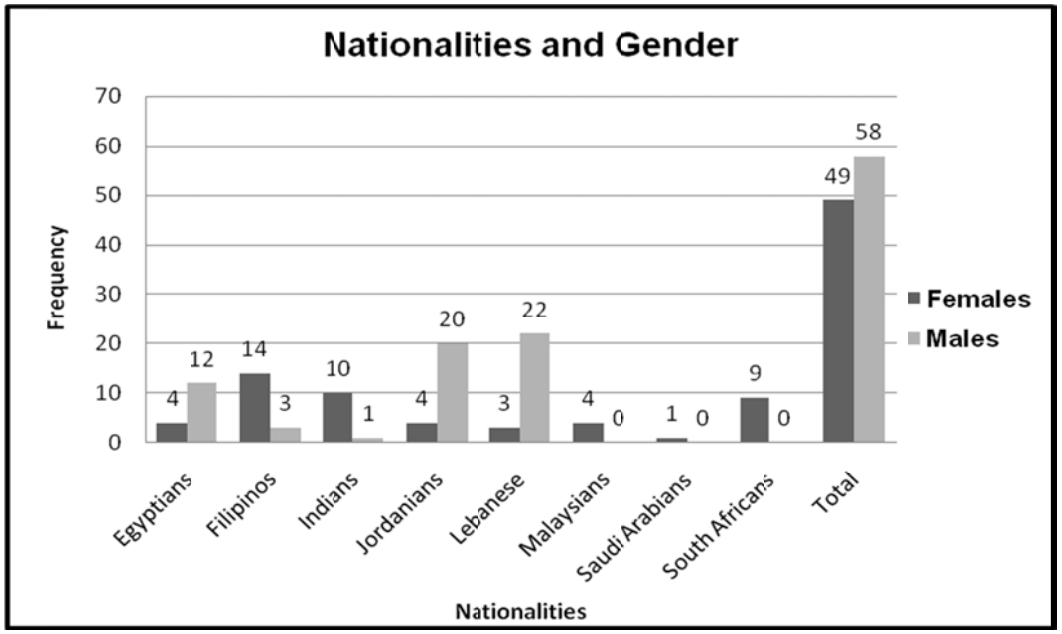

Figure 4.1: Nationalities and Gender

4.3 SECTION B: CODES AND THEMES THAT EMERGED FROM THE INTERVIEWS

4.3.1 Codes that emerged from the interviews

The codes that emerged from the interviews are described in table 4.1

Table 0.1: Codes that emerged from the interviews

Code	Evidence: Example of quotation (source/number of Interview in brackets)	Interpretation
The following codes are related to Cultural Awareness		
Different	*...It is different working with other nurses from other countries...* P 4, line 69	Diversity refers to cultural and human differences
Difficult	*...It is very difficult to sometimes work with other cultures...* P 6, line 71	Differences in language, conflicting beliefs and lack of respect for the individual uniqueness
The following codes are related to Barriers in Communication		
Barrier	*...There are language barriers in the OR...* P 13, line 21	Trans-cultural communication
Dialogue	*… They speak in a different language…* P 10, line 18	Different nationalities speak different languages
No understanding	*… It is difficult to communicate; the other nurses will not understand us…* P 5, line 6-7	Misinterpretation of concepts
Conflict	*… They will understand it their way, and that can cause conflict…* P 7, line 2-3	Failure to communicate efficiently, can lead to uncivil behavior
The following codes are related to Team Nursing		
Teamwork	*...Currently with the teamwork we are doing well, but we are not excellent yet...* P 9, line 47-48	Teamwork in OR is important to render safe patient care
Uncooperative	*… It's simply because the people been really uncooperative…* P 12, line 54	Collaboration is absent in the group cohesion in the OR
Disharmony	*… There is a lot of disharmony…* P 11, line 51	Team relations are distorted
Negative	*… Some is working separately, others working against the group…* P 3, line 30	No shared goal or vision present in the PO nursing team
Trust	*… They wanted him to get in some trouble to destroy the trust relations…* P 4, line 39-40	Support and reliance is important in teamwork
The following codes are related to Interpersonal Relations		

Association	*… Some of the Jordanians didn't want to mix with us…* P 1, line 194	Poor team relations
Interdisciplinary relations	*… Some of the male nurses are very close to some of the surgeons…* P 10, line 203	Marginalization
Mobbing	*…Because of the governing rules on gender in this conservative environment, there are 'gangs' in the OR…* P 11, line 94-95	Lateral violence
The following codes are related to Lateral Violence		
Gossiping	*… There is so much gossiping in the OR…* P 5, line 128	Disruptive and intimidating behavior
Infighting	*… I experience a lot of fighting amongst the teams…* P 4, line 129	Unhealthy working environment
Hidden instruments	*… I prepared for the case; when the procedure started, some of the items were not there…*P 2, line 162	Individual employees stand out as stars
Sudden broken equipment	*… Suddenly I discovered the lenses of the microscope is loose, it would have fallen onto the patient's face…* P 3, line 160-161	Employees are afraid to appear less knowledgeable
Set a trap	*… When I'm really angry at somebody, I will kill him or set a trap for him…* P 10, line 173	Sabotage
The following codes are related to Organizational Discrimination		
Division	*… The system here promotes discrimination between the different nationalities…* P 6, line 151	Negative organizational outcomes
Security	*… I am from India, I feel my job is not secure…* P 8, line 196	A lack of organizational support
Opposition	*… The organization cause very bad competition among the different nationalities…*P 12, line 19	Organizational ignorance
Differentiation	*… Here, we are being made aware of the differences between us due to the differentiation that the organization makes between the various nationalities as far as accommodation and salaries are concerned…* P 11, line 27-29	Organizational discrimination
The following codes are related to Self Worth		
Support	*… We are very close and will support each other because we in the same boat…* P 5, line 147-148	The nurses from the assumed inferior culture developed coping mechanisms
Respect	*… Everybody must work together; they should respect each other…* P 7, line 122	
Humiliation	*… I am from the Philippines and we are being humiliated…*	Feelings are demoralized

	P 13, line 230	
Devalued	*… The senior nurses are shouting at us and the different nationalities try to push one another down…* P 9, line 34-35	Feelings are demoralized
The following codes are related to Dominance		
Dominant	*… The Arabic males are domineering by nature; the Arabic people thinking of themselves, they are something great…* P 13, line 242-243	The so-called superior culture
Submissive	*… The Indian female nurses are submissive, silent, they will not talk…* P 3, line 9	The so-called inferior culture
Superior nationality	*… As Arabic males, we feel superior…* P 9, line 257	The male nurses are the bread winner of the family
Inferior nationality	*… That is the Jordanian and Lebanese talk to us the inferior culture, they will just point to us…* P 8, line 236-239	Degrading behavior of the dominant culture
Bossy	*… They speak wrong words, they are bossy…* P 5, line 189	Power control of the male dominance
The following codes are related to Power Struggles		
Power	*… In the Arabic culture, the male nurses need power and to rule the group…* P 13, line 240-241	The struggle for organizational position
Position	*… There is some struggle with the Arabic males. I think all the Jordanian males want to be in charge…* P 1, line 193-194	The dominant behavior of the Arabic male nurses
The following codes are related to Fear		
Victimization	*… And sometimes your fear that may be you'll be victimized…* P 8, line 25	Lateral violence
Afraid	*… I do not want to say anything because I feel so afraid…* P 6, line 10	Fearful behavior due to oppression
Speak-up	*… I am an Indian nurse; I'm scared to speak out…* P 5, line 14	Low self-esteem
The following codes are related to Gender		
Males	*… Some of the males are very difficult to work with…* P 6, line 81	Gender roles are perceived as difficult complicated
Females	*… Gender makes a big difference, especially the males. Females tend to be very submissive…*P 2, line 43	Women is more inclined to be submissive
The following codes are related to Leadership		
Female leadership	*She might be seen as too*	The Western female leader is

	liberal… P 11, line 276	considered a threat to the dominant culture
Democracy	*… The current style is democratic…* P 1, 26	Most of the participants perceived a participative leadership style
Autocracy	*… The disadvantage of autocracy; some staff would rebel against it, as it would make them powerless…* P 13, line 96-97	Autocracy was seen as good, but applying it continuous would be negative for teamwork
The following codes are related to Empowerment		
Mentorship	*… The Arabic nurses will not coach the new staff inside the rooms…* P 7, line 228	Sabotage

4.3.2 Themes that emerged from the interviews

Table 0.2: Themes that emerged

Themes		
Cultural Awareness	*… They trained us in the beginning when we started here, we attended lectures on multiculturalism…* P 1, line 89	Most of the participants were culturally incompetent
Barriers to Communication	*… Something I've noticed. Communication is very important to teamwork…* P 2, line 1 *…Many staff in the OR does not understand each other may be because of the different language speaking, and it is causing many problems…* P 10, line 13-14	Communication was seen as important for teamwork and patient safety in the OR
Team nursing	*...Actually the teamwork in the OR, we can say is sometimes it is very much good and sometimes it's really bad…* P 12, line 65-66	Teamwork is perceived as good and bad due to cultural differences, gender and the power struggle in the OR.
Patient Safety	*… I do not like to communicate with anybody when there is an incident…* P 3, line 8	Participants were aware of the importance of patient safety, but was more afraid of the intimidation of the dominant culture
Interpersonal Relations	*… That's why we don't share or communicate every problem, as they will bully us afterward…* P 13, line 142 *… If the nurses do something wrong, the doctor would talk to the Arabic nursing staff and they are criticizing or insulting the nurses from other nationalities…* P 13, line 78-79	Due to intimidation and the power struggle and control of the dominant culture, there are many interpersonal relational problems

Lateral Violence	*…We as nurses want security and want to be protected, that's why some of the male nurses would get very close to some of the surgeons. This close relationship with the doctors will sometimes scare the other nurses, especially the female nurses. It will cause trouble for them in their work…* P 11, line 217-219	Lateral violence as been a sign of oppressed group behavior was evident in the OR
Organizational Discrimination	*… I wish that the organization would not differentiate between the different cultures, as it is causing a rift between us and it is bad for teamwork…* P 9, line 210-211	Organizational discrimination was a definite factor that inhibited team nursing in the OR
Self worth	*… The other staff in the OR takes advantage of the Indian and Filipino nurses...* P 8, line 94	Due to the low self-esteem these nurses were socially distorted
Domineering Culture	*The Arabic nurses are not familiar with democracy and they are domineering by nature. The disadvantage is that some staff would rebel against it, as it would make them powerless…* P 13, line 233-235	The perceived dominant culture was marginalized.
Power Struggles	*… The male Arabic nurses need to have the position, so they will create and make a lot of damage for everybody…* P 6, line 17-18	Power struggle is a sign of oppressed group behavior
Gender	*… The female nurses are intimidated by the male nurses, but the male nurses appreciate the education of the SA nurses…* P 10, line 57-59	Low self-esteem of the females and the Arabic male nurses taken advantage of the western education
Fear	*… That's why I keep quiet; I do not want to say anything because I feel afraid…* P 8, line 205 *… … I will face the one who makes me angry…* P 12, line 13	Low self-esteem nurses are intimidated by the dominance of the majority male nurses
Leadership	*… Arabic male nurses cannot accept 'no' from a female manager; when I want to take my break and she says no, I will pretend that I want to go for prayer to get my way with her…* P 11, line 113-115	Arabic males found it difficult to submit to a female leader
Mentorship	*… The Arabic staff thinks they are superior, so they do not share information with us…* P 12, line 206-208	To stand out as stars, the male nurses don't want to share their knowledge, therefore impeding teamwork

4.4 SECTION C: CONSTITUTE PATTERNS THAT EMERGED FROM THE INTERPRETATIVE FINDINGS

Table 0.3: Four Constitute Patterns

Four Constitute Patterns	Themes			
1. Multiculturalism within PO nurse teams contributes to complex group dynamics	Cultural Awareness	Barriers to communication	Team Nursing	Patient Safety
2. The pervasive influence of the medical model and power struggle on group cohesion	Interpersonal relations	Lateral violence	Organizational Discrimination	Self worth
3. Dominance renders the PO nurses powerless	Domineering culture	Power struggle	Gender	Fear
4. Empowerment is the panacea to improving team communication	Leadership	Mentorship	Empowerment	

4.4.1 Constitute patterns that emerged from the interpretive findings

4.4.1.1 Multiculturalism within PO nurses teams contributes to complex group dynamics

The concept of global workforce diversity requires openness to understanding differences in people, are appreciative of other people's values and ways of doing things (Jooste, 2003:177). It is therefore required from the PO nurses to develop a high cultural sensitivity to support the diversity in the workplace setting.

According to Jooste (2003:178) cultural diversity refers to the variety and differences in values, lifestyles, customs and practices of a defined group. These attributes are reflected among the PO nurses and is further evident in the human spectrum of differences that is age, ethnicity, gender, physical attributes, race and social orientation.

> *… We had lectures on different cultures during my basic nursing training, but being here in the Middle East, I experience it for the first time, and sometimes it is difficult…* Participant 4, line 67-69

> *... Sometimes the whole team might suffer because of the one with the bad attitude. This is the experience in all the cultures in the OR. This put pressure on the team and everybody would be stressed...*
>
> Participant 7, line 44-46

Participants expressed their feelings of being unappreciated despite working within the team and helped in the delivery of peri-operative care. This participant perceived that the racial origin contributed towards this indifferent treatment and felt that in order to survive in their everyday world they had to endure such experiences as depicted in the following extract:

> *... But, the Arabic people thinking of themselves, they are something great, and if you are dark, they treat you different...*
>
> Participant 8, line 88-89

In conjunction with not feeling appreciated, participants also reported that at times they felt inadequate. Surviving in an everyday world when feeling inadequate creates discomfort, anger and sometimes frustration.

These elements of diversity have a lifelong impact on behavior and attitudes of the nursing professionals. Lack of understanding of cultural practices and patterns may result in cultural biases, stereotypes and prejudice that may lead to loss of meaningful communication, and loss of highly competent staff (Jooste, 2003:179).

It is evident that members of the healthcare profession need to render culturally safe and congruent care with trans-cultural communication, to answer the immense difficulties and obstacles at the various levels.

Considering the dynamic in the OR, it was evident that to complete a team task, the PO nurses within the environment had to dynamically share information and resources, coordinate the activity necessary for task completion and dynamically adjust to the demands of the task.

> *…Many staff in the OR does not understand each other may be because of the different language speaking, and it is causing many problems…*
>
> Participant 10, line 15-16

> *…… They speak in a different language, but you know it is so bad when the doctors and nurses communicate in Arabic knowing that I, the primary nurse*

> *of the patient does not understand what they are saying. Very valuable information gets lost, no details….*
>
> Participant 12, line 18-20

Within the study setting, in the OR, the participants experienced difficulty in understanding the transfer of information when the patient was handed over between areas. Valuable information was lost and it could result in disastrous effects for the patients as well as for the PO nurses.

The essence of efficient team coherence is effective collaboration and communication (Leonard & Bonacum, 2004:85). Gillespie et al., (2010:735) argued that the absence of thereof has been associated with devastating adverse events that can impact on care delivery, and patient safety.

It is therefore imperative that communication amongst a multicultural workforce, whether verbal, written, or non-verbal must be received in a manner that does not allow room for misinterpretation. Differences in language, symbols of communication, stereotyping, conflicting beliefs and lack of respect for the uniqueness are difficulties that can interfere with PO patient care (Hamlin & Anderson, 2011:291).

According to Jooste (2003:181) a person's culture includes all of the learned patterns of beliefs, values and behaviors that belong to that particular group or society. It is evident that employees prefer to work with people of the same race gender and education and confirmed in the following extract from one of the participants in the PO setting.

> *... Sometimes we work in harmonious relationships, but when it comes to teamwork, it's been neglected because they prefer to help more their own nationalities...*
>
> Participant 12, line 227-229

> *... These groups are strong and within their nationalities they would only support each other...*
>
> Participant 11, 222-223

Working with multicultural team members requires recognition of individual's unique values, beliefs and practices to overcome differences. The PO nursing practice or environment therefore have to have a broad understanding of the impact of social and cultural values on the nursing care practice and their interaction.

In obtaining cultural knowledge, it is critical to take into account the concept of intra-cultural variation. It was evident from the literature that there is more variation within cultural groups than across cultural groups (Jooste, 2003:184). It was confirmed in the researcher's area of practice where the diverse cultures experienced the differences among the groups.

> *….. But, some of the Jordanians didn't want to mix with you and they will be rude to you and they will answer you in a nasty way, and they don't talk to you….*
>
> Participant 1, line 194-195

> *... The politics in the OR is like this; it is between the Jordanian and Lebanese Arabic staff, self they are fighting; they do not like each other...*
>
> Participant 7, line 201-202

No individual is a stereotype of one's culture of origin, but rather a unique blend of the diversity found within each culture.

Therefore, the PO nurse practitioner should develop the skill to conduct a cultural assessment within the OR environment (Campinha-Bacote, 2003:5).

Diversity within the health care industry is not a new issue. The concept of culturally diversity within the PO nursing team may lends itself to learning more about the different views of caring behavior (Beheri, 2004:216). Culture is considered to have a powerful influence in one's understanding of health. According to Hamlin and Anderson (2011:291) it affects the individual's interpretation of and response to health care delivery.

There is strong support in the literature advocating the imperative for improved teamwork through collaboration and communication among PO nurses (Silen-Lipponen, Tossavainen, Turunen & Smith, 2005:22). Thus, the unfamiliar world that participants experienced created unpleasant feelings. Although some participants commented on their experiences of the absence of teamwork or lack thereof, one participant spoke of her positive experience of good teamwork:

> *... The teamwork in the OR is good, but 50% thereof is due to age and cultural differences and also because of differences in the qualifications...*
>
> Participant 4, line 8-9

> *... Negative things would damage the teamwork and it might have long-lasting effects in the OR...*
>
> Participant 7, line 4-5

In the OR, teams work under conditions that change frequently. According to Silen-Lipponen et al., (2005:22) teamwork in the OR changes its membership dynamically, and has to integrate different professional cultures and nationalities.

> *….. I never had any training on working in a multicultural environment, only here have I experienced it. It is very difficult to sometimes work with other cultures…*
>
> Participant 6, line 70-71

> *... It is a group of people who are working in harmony to achieve the same goal. The objective of everyone should be to achieve the same goal. Everyone should know their competencies within the team...*
>
> Participant 9, line 121-123

From the participants perception was when experiencing difficulty in working and interacting with members of other cultures. It was evident from their interpretation that there was a need for team cohesion is to have goals.

Manser (2009:143) postulates teams as two or more individuals who work together to achieve specified and shared goals. According to Leonard et al., (2004:85) OR teams have task-specific competencies and specialized work roles, use shared resources, and communicate to coordinate and to adapt to change.

> *….When you come here, you are coming from the different places and you come here, then you will only know the other cultures and my culture is different from your culture. But for me, everybody must work together, they should respect each other...*
>
> Participant 8, line 73-75

> *... Teamwork must occur in a positive way, not in a negative way; everybody must work together, trust and respect each other...*
>
> Participant 1, line 34-35

From the participants' perspective, it was clear that they perceive teamwork as a group of people working in harmony to achieve a goal. The true meaning of intergroup relations is that of support, trust, respect and to understand each other

and the differences of cultures within the PO nurse setting. But, they also express their concern about the various factors that would influence true collaboration;

> *... Traditions and culture are huge barriers in forming close relations in the working environment. Not everybody is cooperative and understanding. Attitude is also a problem with some staff members....*
>
> Participant 2, line 61-62

The particular responsibilities of PO and the provision of care is highly technical (Smith, 2010:577). Hamlin and Anderson (2011:292) confirmed that the multicultural nature of the PO workforce and the significance of certain cultural beliefs incorporated into the nursing practice might change one's thinking and reaction to the various processes in the OR.

Teamwork in the OR, leadership and the different education levels and its role in assuring patient safety and staff well-being were identified as the most prominent factors ensuring collaboration in the OR (Silen-Lipponen et al., 2005:29). Kaplan, Mestel & Feldman (2010:415) stated that conflict, intimidating and inappropriate behavior undermines morale within the PO setting and impedes the ability to provide effective and safe patient care.

> *… When I see something wrong, I will remain silent, it is better, but it is bad if teamwork is not good, it will harm the patients…* P 4, line 44

From this significant statement, the participants gave meaning to the effect of team cohesion on patient safety in the OR.

Communication failure as the result of poor inter-professional collaboration results in increased patient harm and increased job dissatisfaction of nurses (Rose, 2011:8). The reality does not reflect the true impact, due to nurses under-reporting such events (Corney, 2008:165). Several participants gave meaning to their experiences to avoid conflict in the OR, that they will rather not report errors due to their fear.

> *... The Arabic nurses fight with everybody, but the Indians and us the Filipinos would rather avoid arguments. That's why we don't share or communicate every problem in the OR...*
>
> Participant 13, line 201-203

They further stated that safe patient care is associated with the quality of the PO nursing practice work environment. From the nurse's perspective, it was found that if

their work environment supports professional practice, they will most likely be engaged in their work, thereby ensuring safe patient care.

Manser (2009:145) confirmed that teamwork and communication problems were the strongest predictors of surgical error. But, considering the complexity of group dynamic and the inter-professional dynamic of the PO environment, failure to communicate well, might be associated with uncivil or disruptive behavior (Guglielmi, 2011:106).

4.4.1.2 The pervasive influence of the medical model and power struggle on group cohesion

Interpersonal conflict between nurses is common. A study performed by Vessey, DeMarco, Gaffney and Budin (2009:299) looked at lateral violence as intergroup conflict. It appear to begin before the nurse is qualified, thus during the process of nursing education (Corney, 2008:165).

Zakari et al., (2010:298) argued further that inter-professional conflict makes efficient collaboration complex and as a result impeded effective communication and teamwork. Participants in the PO setting confirmed the intricacy of conflict and that it may be competitive or disruptive.

> *…Some people you know, if you talk, they will understand it their way, not exactly the way the thing is, and that can cause conflict….*
>
> Participant 2, line 2-3

Smith (2010:6) stated that disruptive behavior within an OR is one of the difficult issues to deal with. It is not a new concept to any OR, because it does occur and according to the Joint Commission for Accreditation of Health care Organizations (JCAHO), disruptive behavior is classified as a sentinel event.

Nurses can find themselves in conflict with those they work with and disparities such as lateral violence and a hostile workplace environment remain a serious problem (Moore & Putman, 2008:103).

Inter-professional team collaboration amongst the team members in the PO setting has became increasingly recognized in the literature as important to nurse retention, job satisfaction and safe patient care (Barrett et al., 2009:343).

According to Hoel, Glas, Hetland, Cooper & Einarsen (2009:453) lateral violence or bullying can be directed at the individual of the same peer group. Matheson and Bobay (2007:227) stated that it is carried out deliberately or increasingly and is considered to be the root cause of an unhealthy and unpleasant work environment. Embree & White (2010:166) confirmed the phenomena and stated that the reason for these feelings is due to role issues, oppression, strict hierarchy, low self esteem, perception of powerlessness, anger and power dynamics.

Lateral violence is often displayed by individuals perceived as being in the 'top levels of the OR hierarchy' against those individuals who are lower in the hierarchy (Matheson & Bobay, 2007; 228).

> *... Here, there is verbal abuse, the senior nurses are shouting at us and the different nationalities try to push one another down...*
>
> Participant 9, line 121-122

The effect causes humiliation, offense and distress and may interfere with job performance.

> *... I am from the Philippines and we are being humiliated many times and the doctors will shout at us; we feel they don't respect us... Participant 13, line*

> *… I feel so many times to leave this hospital, but I cannot, I signed a contract and I am from India. I feel my job is not secure….*
>
> Participant 8, line 12

The study revealed many unpleasant experiences of the nurses from other nationalities considered from the inferior culture (non-Arabic females) towards members of the superior culture (Arabic males). In addition to the difficulties in teamwork, bullying in the PO nursing care created unpleasant experiences during their everyday working lives

Lateral violence might arise from several origins, but most frequently from oppressed group behavior and further from learned behavior within the given workforce (Embree & White, 2010:170). It underpins disruptive behavior as tense nurse-to-nurse relationships. a Lack of structure and consistency can be alluded to a chaotic work environment, different communication styles and a lack of organizational support. The result is conflict between experienced and new nurses (Barrett et al., 2009:343).

> *… I experiencing a lot of backstabbing, we are too afraid to get close to one another due to the closed groups…*
>
> Participant 12, line 123

The PO culture can be one of distrust, intimidation and sabotage because;

- Individual employees want to stand out as stars and keep information to themselves to do so
- Employees are afraid to appear less knowledgeable, so they sabotage others, and
- Long-term employees do not support new employees and leave them to 'fend for themselves' as they adjust to working in the OR.

> *…. Somebody in the OR will hide your items and or instruments that you need for the procedure. It happened also to me, I was allocated to scrub for a intra medullary nailing for a fracture left femur. After I've prepared everything and made sure all was ready, I go to scrub my hands. Intra-operative when the surgeon asked for the specific size nail, I discovered that it was gone and I knew I prepared it. I then realized someone must have hide it again….*
>
> Participant 9, line 167-172

> *... Items will fall out of the sky to impress the surgeon when the item was previously reported being out of stock...* Participant 3, line 55

> *... Some staff will set traps for one another to bring them down, because of jealous of each other...* Participant 6, line 49

According to Barrett et al., (2009:348) there are certain commonalities that fuelled disruptive behavior, and these were mirrored in the participant's workplace in the OR.

These behaviors can cause PO nurses within the team set-up to hesitate to address a patient need or safety concern, when one arise (Smith, 2010:577). It was further explore by Barrett et al., (2009:343) that an unhealthy, disruptive and intimidating work environment not only contribute to conflict and stress, but also impacts negatively on patient care.

> *... The relationships are divided between the different nationalities. The conflict in the OR makes me feel stressed and restless and I don't want to carry out the work...*

Participant 9, line 208-209

> *... I think we must do picnics to socialize with all the team members from the different nationalities outside of the working environment. I'm sure it will increase teamwork because we will know who the person is and it will increase understanding of our differences...*

Participant 12, line 111-113

Team building activities were suggested from a few of the participants, which indicated their understanding that collaboration is needed to formulate group cohesion within the multicultural team. It might improve their communication and relations with each other. But, in contrast with some of the Arabic participants, they stated that,

> *... In the working environment the genders have to mix, otherwise no mixing of genders is allowed outside of the working situation, according to our religion and the rules of our tribes...*

Participant 11, line 266-267

Team building activities will be a challenge, as one will have to take these cultural sensitivities into consideration (Barrett et al., 2009:346).

As stated by Barrett et al., (2009:343) lateral violence occurs when nurses overtly and covertly direct their dissatisfaction inward toward each other, themselves, and those who are less powerful (Barrett et al., 2009:343).

The effect causes humiliation, offense and distress and may interfere with job performance.

> *…. I am from the Philippines and we are being humiliated many times and the doctors will shout at us; we feel they don't respect us….*

Participant 13, line 52-53

The participants' experience of this phenomenon caused increased stress and hopelessness among the PO nurses. Thus, lateral violence in the PO environment has been linked to behaviors of oppressed groups (Matheson & Bobay, 2007:227). This destructive, demeaning phenomenon is linked to nurse dissatisfaction and high attrition and is believed to contribute negatively to nursing and patient outcomes (Dimarino, 2011:584).

> *... From what I have seen in the OR it is the Indian and the Filipino nurses, they are not open to talk, they, it's oppressing them...*
>
> Participant 3, line 288-289

Intimidating behavior can be viewed as eye rolling, gossiping, whispering, saying hurtful things and trying to embarrass someone in front of others (Kaplan et al., 2010:495). Bullying can further be described as “overt and covert non-physical hostility such as anti issue, sabotage, under wining, infighting, scapegoating and bickering (Stevens, 2011:190).

> *…. If the nurses do something wrong, the doctor would talk to the Arabic nursing staff and they are criticizing or insulting the nurses from other nationalities….*
>
> Participant 13, line 46-49

> *… There are language barriers in the OR, especially if there's a difficult situation with the patients, the doctors will speak Arabic to one another. If we mention to them that we don’t follow, they would shout at us….*
>
> Participant 1, line 15-17

> … It is easy to work with Indian and Filipino nurses, they really have the spirit of teamwork…
>
> Participant 3, line 13

It was evident from the participant’s experiences that there were very little cooperation and understanding among the team members. Although they expressed the understanding of the meaning of true collaboration in teamwork as that of trust and respect for one another. They further stated that being loyal to each other and demonstrating good communication skills is what contributes towards good interpersonal relations.

PO nurses experienced relational problems and it was apparent in the researcher’s workplace due to the patriarchal medical model which tended to subsume nurses into 'doctors handmaidens'. Corney (2008:165) summarized it as that medical staff is largely responsible for nurses to experience this feeling of intimidation.

> *….. Most of the male nurses are close to the doctors, they can go to the doctors to tell about you. They can also give you problems...*
>
> Participant 8, line 51-52

In the following extract, participants commented on having to prove themselves so as to gain recognition in the PO environment. They wanted to be recognized as professional nurses, as without it, it will render team cohesion negatively.

> *… I've seen most of them looking for the fault only, not looking for the good things you are doing…*
>
> Participant 8, line 22

The impact of the hostile violence has great seriousness as its effect is that of physical (weight loss, fatigue, headaches and hypertension), emotional and psychological (fear, anxiety, frustration & mistrust) constraint. Habermas' critical social theory substantiated these phenomena.

These feelings are demoralizing, and its vulnerability impedes a negatively charged attitude in the PO environment (Corney, 2008:166).

> *... I think the management must support the nurses more, especially in the OR. This is a high stress environment. Because if they don't want to recognize the good nurses, it will affect the teamwork negatively, but maybe the discrimination in the system of the organization will not let it happen...*
>
> Participant 4, line 277-278

Discrimination within the workplace is still experienced in certain cultures. Generally, cultural conflict of a subtle nature occurs without the leader's notice. Jooste (2003:181) ascertain that minorities suffer cultural biases, overt and covert conflicts, ethnocentrism, and fears of discrimination.

> *….. Because of the diversity of the cultures, we have different kinds of relationships in the OR, a different way of interacting, it changes your thinking. It wasn't a big deal for me as I was raised among different ethnic groups and religions in Beirut. Here, we are being made aware of the differences between us due to the differentiation that the organization makes between the various nationalities in as far as accommodation and salaries are concerned….*
>
> Participant 11, line 256-260

There is emerging evidence that a relationships exists between bullying and negative organizational outcomes (Hoel et al., 2009:453). As previously observed, the Middle Eastern Hospital is an organization with its own culture and is characterized by the

presence of a multicultural society. The participants expressed their concern and they felt unwelcome…

> *.... There is discrimination among the different nationalities by higher management which causes conflict among staff....*
>
> Participant 3, line 80

> *... I have developed good relations with my colleagues in my team, but the system here promotes discrimination that divides people, and it does not enhance teamwork...*
>
> Participant 11, line 49-51

> *... Some staff members have connections with the medical staff and because of their relationship with the surgeon, they will be promoted...*
>
> Participant 3, line 226-227

Hutchinson et al., (2005:120) stated that effective coordination and communication is influenced and promoted when organizational support is available. It can be displayed time for collaborative discussion, information sharing, debriefing and relationship building. The participants voiced their dissatisfaction by expressing their need for support from the organization.

> *… I have developed good relations with my colleagues in my team, but the system here promotes discrimination that divides people, and it does not enhance teamwork….*
>
> Participant 11, line 230-231

> *… I wish that the organization would not differentiate between the different cultures, as it is causing a rift between us and it is bad for teamwork….*
>
> Participant 9, line 67-68

> *... I feel that the system here makes no room for me to vent my anger or to develop as a person so I just keep quiet...*
>
> Participant 11, line 55

> *... I don't feel free to express my anger and secondly I don't feel that I will achieve anything by expressing it anyway...*
>
> Participant 2, line 99-100

Such a ripple effect was noted in a number of studies. Hoel et al., (2009:453) postulate it as a serious problem within the working environment and it can hold substantial cost to the organization.

> *... I have been working for this organization for more than five years and working in a multicultural environment was life-altering to me. It affected me as a person and I had to make huge adjustments as a individual and as a OR nurse...*
>
> Participant 3, line

In the nursing profession, caring means to be concerned about someone and something (Hamlin & Anderson, 2011:291). Participants within their own nationality cared for each by supporting one another throughout their experiences. They spoke of their difficulties and were able to give peer support to each other.

The absence of support from their Arabic colleagues created conflict and difficulties. Yet, despite this, participants were able to develop coping mechanisms to live in their everyday world, as exemplified in the following extract;

> *… Because of the boundaries I tend to stick to my own nationality. We will discuss the behavior and unfair treatment among ourselves. We are very close and will support each other because we in the same boat….*
>
> Participant 5, line

Some participants described how they had to prove themselves in order to survive in their everyday world and the boundaries that the participant referred to were the constraints that they experience in the PO setting.

4.4.1.3 Dominance renders the PO nurses powerless

It has been suggested that the internalized beliefs of nurses about their own inferiority resulted in an ability to take control of their own destiny. Denial maintained the status quo in the PO setting and as a result power relations remained unchallenged (Roberts et al., 2009:291).

As a result, the cultural narration of nursing is for nurses to be subordinate and as such they display the characteristics of an oppressed group, lacking in self-esteem and directing passive aggression towards each other (Matheson & Bobay, 2007:226).

From this perspective, workplace bullying between nurses is viewed as a symptom of the dynamics of socio-political oppression, which is acted out through violence toward colleagues (Stevens, 2011:189).

The dominant group has characteristics to control a lower submissive group, thus the values and norms of the oppressor (dominant group) are viewed as the "right ones" and are forced upon the oppressed group (Roberts et al., 2009:291). The characteristics of the oppressed group are negatively valued. Matheson and Bobay (2007:228) ascertained that these are particularly evident in a group where gender and race differs, especially where men are viewed as the dominant group versus women as the oppressed group. These phenomena were mirrored in the researcher's workplace.

The PO nurses learned from their perception and experience in the OR what the dominant culture is and gave meaning to their everyday interaction among the multiple nationalities. They further determine the cultural climate of the organization.

> *... There's no teamwork in the operating room. The Jordanians always want to take over and they act more superior...*
>
> Participant 5, line 102

> *.... If you have a Jordanian, Indian and South African nurse, the most submissive among them will be the Indian nurse...*
>
> Participant 1, line 115-116

> *.... The Filipino, Malaysian and the Indian nurses will keep quiet and not fend for themselves. The Arabic staff treat the South Africans the same as the Indian and Filipinos...*
>
> Participant 3, line 119-120

The participants from minority groups felt powerless and intimidated in a given situation. They appeared to be powerless to stop the behavior. This may be because it is 'culturally institutionalized' rather than 'perpetrated' by any one individual or group.

Moore and Putman (2008:103) ascertain that multi level and various dimensions of ineffective communication within the health care environment were evident and left leaders helpless. Corney (2008:167) confirmed it by looking at the hierarchical

structure of nursing, power may be seen to be the key issue pertaining disruptive behaviors.

> *.... We must be very sensitive when we deal with the Arabic speaking males due to cultural dominance. We have to be very careful in the kind of words that we use with them as they easily feel insulted even if it wasn't the intent…*
>
> Participant 5, line 199-201

> *...The males have a superior attitude towards other nationalities...*
>
> Participant 3, line 14

Rose (2011:6) argued that social, cultural, professional and educational systems and including power differences, potentially influence inter-professional collaboration.

For true collaboration to occur, all disciplines within the PO environment must be considered equal partners.

> *... Everyone must fulfill his or her role in order to deliver quality patient care. We must respect each team member but I will not accept if a female nurse raise her voice against me. I am an Arabic male. According to our religion we are regarded higher as females as we are the breadwinners and we are taking the responsibilities for the family...*
>
> Participant 11, line 225-228

> *... I feel that some of the male nurses manipulate their relations with surgeons that is part of the organizations administration just gain something, e.g promotion...*
>
> Participant 3, line 213-214

According to Chadwick (2010:154) collaborative PO team members have less individual autonomy, but when integrated the team appears more autonomous. Rose (2011:6) further argued that inter-professional collaboration requires interdependency as opposed to autonomous practice. The participants' understanding of collaboration was reflected from their explanation when they voiced the meaning thereof during the interviews.

> *.... To work together, to share the workload, caring for the weak and to uplift them...*
>
> Participant 10, line 33

> *.... To complete each other and not to compete. To respect each other's colleagues. Single staff cannot produce patient safety, it depends on the whole team...*
>
> Participant 13, line 94-96

Vertical coordination promotes inter-professional collaboration as opposed to hierarchical organizational structures (Rose, 2011:7).

Rose (2011:7) asserts that collaboration implies sharing, partnership, interdependency and also power. Poor dynamics, complex power dynamics, reduced understanding of roles and responsibilities and interpersonal conflict is considered a barrier to successful collaboration (Rose, 2011:8).

> *.... Respect is to accept each team member irrespective of where they come from. Over the years that I've worked here, I became more clear and understanding of the different cultures and their ways of communication...*
>
> Participant 12, line 28-30

It was further observed that oppressed group behavior and how these groups direct their frustrations and dissatisfaction on each other as a response due to a lack of power.

The literature further indicated that nurses mentioned that these events had reduced their confidence and self-esteem (Corney, 2008:167).

> *... I don't like to work in the vascular team as the surgeon is not easy to work with. The Arabic male nurse will make me feel stupid although I know my job in the OR...*
>
> Participant 13, line 44-46

From the literature, cultural disparity, differences in gender, and socialization appears to influence power relationships within teamwork (Chadwick, 2011:158). A further study done by Costello et al., (2011:115) asserted that power disparity is a definite principal barrier to collaboration.

> *... The males are the majority in the OR. I think about 75%. They don't want to work, they just want the titles...*
>
> Participant 2, line 111

> *.... The Arabic staff are not interested in the work they just want the positions...*
>
> Participant 7, line 121

Faulty reasoning and partly expressed messages are major barriers to communication. Arguing, blaming or threatening creates psychological barriers and values, beliefs, jealousies and fear can create personal barriers (Thoban, 2007:82).

> *... I just keep quiet and I don't speak out, otherwise if I will talk to them, the male nurses, I might say something that will upset them very much...*
>
> Participant 12, line 116-117

According to Dimarino (2011:583) patient safety might be at risk when intimidation causes fear or anger in those at whom it is directed. Thus, organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it (Hutchinson, Wilkes, Jackson & Vickers. 2010:175).

> *... That's why we are silent, we will not talk or share information about the problems inside , as they will bully us afterward in the rooms...*
>
> Participant 13, line 127-128

Often this type of behavior was witnessed by the team members, but they were not prepared to support their colleagues for fear that one of them would be the next victim

The meaning of oppression was perceived by them as that of powerlessness and that they feel that regular group discussions might be the solution. Habermas' critical social theory postulates that language and dialogue is the foundation of active communication will free people (Sigurdsson, 2001:208). Freire's model on oppressed group behavior ascertained that by reflection in action, that is by discussion with knowledge, one will be liberated and improvement will be the result thereof (Corney, 2008:166).

4.4.1.4 Empowerment is the panacea to improving team communication

Jooste (2003:178) stated that strong culturally sensitive leadership is essential to meet the growing diverse nursing profession of diverse cultures worldwide.

Nursing leadership was found to be the driving force in the OR and is an important factor in creating a positive work environment and a culture of safety (Hoel et al., 2009:454).

> *... Our leadership is very good, the current style is democratic; a male or female manager, it does not matter...*
>
> Participant 3, line 236-237

The key to establish a healthy environment requires effective leaders and efficient leadership. According to Barrett et al., (2009:343) nurse managers' commitment is of critical importance in creating an environment that support job satisfaction. Retention through the promotion of a cohesive, collaborative environment was seen as detrimental to enhance team coherence in the OR.

To be able to establish teamwork in the PO setting, one should focus on building trust, identifying and changing roles, engaging and empower all the staff members in the decision making process.

Assumptions are made that male and female leaders differ in personal qualities. Generalizing about male and female styles of leadership needs to be done with great caution because stereotyping can have negative effects.

> *... I don't have a problem with a female manager, as she treats us with respect. Both male and female managers should have leadership qualities in order to manage the multicultural staff...*
>
> Participant 5, line 130-133

> *... I feel that genders are equal in this position...*
>
> Participant 7, line 17

The male Arabic participants perceived a male and female manager as equal and in general they didn't have a problem with gender in a leader position. But, from the South African participants they felt a male manager will not be suitable as the males in the Arabic nationality were afraid to reprimand or approach each other and further it will not work as the majority is male staff. The male nurses were found to submit to the older male leader who is considered to be the leader of the tribe.

It was evident from the PO nurses' perception that there is not much difference between the leadership styles of the male and female leaders in the OR. This finding concurred with that of Jooste (2003:191) which stated that there is a minimal

difference found between the needs and values of male and female leaders. But, it might be useful to further research the phenomenon of male and female leadership in a multicultural PO environment and the effect thereof on group cohesion.

Female leaders are considered to be more successful due to how women are socialized, and how followers react to their leadership styles. In contrast to Smith (2010:578) who stated that male and female leaders exhibit similarities of task-orientated and people-orientated behavior in the OR environment.

Role modeling with positive interactions and holding each other accountable could further be considered (Barrett et al., 2009:343).

From the participant's experiences, it was evident that there was a lack of adequate mentorship and role modeling in the PO environment.

> *….. I think most of the old staff is taking advantage of this new staff, they are really abusing them. The new staff don't know the environment, and they are afraid….*
>
> Participant 8, line 127-128

The participants voiced their satisfaction being interviewed as this gave them an opportunity to describe the meaning and understanding of their interaction with other nationalities in the PO environment.

Although some of the participants didn't have a perception of the concept of empowerment, others stated that empowerment would give them an opportunity to improve their knowledge of each other and to be able to voice their opinions.

Empowering through leadership, creates a supportive collaborative environment and Barrett et al., (2009:344) stated that satisfaction with nursing leadership is positively correlated with group cohesion.

The first notion of the study's theoretical framework was Habermas' critical social theory. The impetus of Habermas' theory within this study setting was that of communicative action. According to Sigurdsson (2001:207) Habermas' theory consisted of two important areas. Habermas postulated that culture and cultural traditions are transmitted through language. He defined culture as the 'stock of knowledge from which participants in communication presents themselves with interpretations as they reach an understanding about something in their world. He further ascertained that 'understanding and meaning is reached through language,

and through language used in communicative action, culture is transmitted and maintained (Sigurdsson, 2001:208).

Habermas referred to one's understanding, as an interpretive store. It is from within this subjective core that the individual understand and give meaning of themselves and their world. Thus, when two or more people act communicatively to reach mutual understanding, a shared life world is created.

Therefore, according to the critical social theory of communicative action, it is only by challenging the inability to act communicatively, and through discussion that increased understanding and meaning might be gained.

4.5 DISCUSSION OF THE COMPREHENSIVE INTERPRETATION

According to Habermas he referred to hermeneutics as the methodology of choice for studying social phenomena (Sigurdsson, 2001:209). Hermeneutics, applied in this study, was to explore the lived experiences of multicultural PO nurses to better understand the social, cultural and political context in which these experiences occurred. Its intent was to transmit experience, beliefs and judgments from one participant to another.

The goal of this study through the hermeneutic inquiry was to identify the PO participants' meanings of their lived experience within a multicultural workforce in the OR environment from the blend of the researchers understanding of the phenomenon, the participant-generated information and the data revealed.

Their experiences were described from the context of their own unique experiences. The following objectives were set for this study: to interpret the meaning and understanding of:

- To explore the perceptions and experiences of PO nurses in a multicultural environment.
- To explore interrelationships amongst staff members
- To establish leadership styles within this multicultural workforce.

The findings revealed both positive and negative findings. Positive findings included that multicultural communication skills can assist the PO nurses to view cultural diversity as an asset and to grow in new positions and directions (Jooste, 2003:190)

Conversely, some reported that intimidation, lack of trust and lack of team cohesion were evident in the PO setting. Jooste (2003:189) stated that intercultural

misunderstanding leads to cultural biases, conflicts, racial accusations and hatred amongst people of diverse cultures.

Participants felt that their cultural differences were factors prevented them from being valued by their contemporaries and also accounted for the way in which they were treated.

Worldwide, the nursing workforce is declining due to various reasons. It is somewhat ignominious to have to concede that workplace violence, in some of its many forms, is now considered to be a leading factor in the increasingly high rates of attrition. Corney (2008:168) concurred with the conclusion and stated that if disruptive, intimidating behavior remains unexplored and a vial drawn across the subject, the rate that people leave the profession will prove detrimental to society.

It is important to note that these findings are consistent with Alexis and Vydelingum (2005:462) study. Freire's model of oppressed group behavior for understanding macro structures of oppression within the nursing profession. As such, the critical reflective practice that underpins the model might be a useful tool in PO nurses workplace in a hospital in the Middle East.

Drawn upon the critical social theory (Habermas) and the oppressed group behavior model (Freire) it appears that social conditions distort the individuals self perception. Therefore, in the PO setting, the nurses should be given an opportunity to have insight into these distorted conditions. According to Habermas and Freire, they have to find ways to liberate themselves (Roberts, 2000:156).

Using both models, in contrast to its usefulness within the PO nursing practice, Roberts (2000:158) postulate that the oppressed group behavior model had no consideration of how the inner working of a organization might have perpetuated bullying among the PO nurses. For the purpose of this study therefore, reflective practice in the nursing team practice might be useful to liberate them from the various constraints.

It became obvious that the disruptive behavior was fundamental to the very structure of PO nursing itself and, as such, had a normative effect. To an extent whereby it was expected and although it's effects were in some instances devastating, it went largely unreported.

It seemed so 'congenital' to nursing that victims took quite some time to realize that they were actually being bullied until it was pointed out to them by another.

The bullying behavior within the nursing profession has occurred across a variety of health care settings (Stevens, 2002:190) as it is evident in the study setting. The phenomenon appears to be integral to the culture of the PO environment.

Some of the staff within the PO setting felt that they had no one to go to when they needed help because of the seemingly covert acceptance of bullying. Whatever measures were there for dealing with this issue were clearly inadequate.

The finding from this study revealed a lack of team cohesion, due to inadequate communication, interpersonal conflict and cultural prejudice and imposition. Participants questioned why teamwork that comprised of bullying discrimination and intimidation were not addressed, for them to be able to survive in their everyday world. This finding affirms those from a number of previous studies (Alexis & Vydelingum, 2005:462; Yu Xu, 2010:66).

Some participants perceived that their 'inferior culture' in comparison with the acceptable 'superior culture' played a significant part in their 'lack of adequate communication and therefore the 'silent, passive-aggressive behavior' in spite of patient safety and what goes wrong in the rooms.

Surviving in an everyday world like the OR in a Middle Eastern Hospital, that contained intimidating behavior within team nursing practice, created some difficulties for these participants in terms of building trust relationships with efficient communication styles with their peers. Building a good relationship with all of their colleagues was fundamental to their survival; however, for some this was not possible because the value, appreciation and the support were not available. Although each participant's experience was unique, these findings are similar to those previously reported oppressed group behavior in an OR environment (Bigony, 2004:444; Yu Xu, 2010:66 & Rose, 2011:555).

There is a need for the Nurse Manager and charge nurses to create an environment that is conducive for team cohesion and active communication that reflects the value difference model and empowerment of Habermas' critical social theory.

In terms of support, the Filipino, Indian and South African nurses felt that they could rely on their ethnic counterparts in order to cope in their everyday world. This current

research concurs with the findings of Yu Xu (2010:66). Participants recognized a commonality of experience and culture between self and other members of the group and according to Stevens (2002:190) this is referred to as 'empathetic identification'. As there were other nurses from different nationalities that they could identify with, these participants sought help so as attempt to live comfortably in their everyday world.

Some of the participants were seen as a less dominant group, and they felt that their identities might be eroded. Therefore, to maintain their identities in the workplace, they sought support from each other and the considered also to be the 'inferior' group, as this was fundamental for their well-being. Similar findings were identified by Xenia (2004:266), who explored people belonging to a non-dominant group moving into new environment. This serves to highlight that, in order to cope in the PO environment in the Middle Eastern Hospital, support is necessary.

4.6 SUMMARY

In this study, the phenomenological reduction and analysis of the data has been conceptualized in the perceptions and experiences of the PO nursing teams and their views of the factors influencing or optimizing were revealed in 6 themes. The themes represented what the researcher believed to be the essence of the participants' lived experience.

The essential themes and constitute patterns must be understood in the context of their interrelationship.

4.7 CONCLUSION

It is clear from the results of this study that the PO environment containing a multicultural workforce has created some challenges and as such, affected their views and perceptions of the PO nursing team care in a Middle Eastern Hospital.

Many of the participants felt that their contributions were not valued. It is fundamental to acknowledge diversity in a multicultural environment.

Chapter five (5) will describe the limitations of the study and draw upon the final conclusions of the study and suggest recommendations.

CHAPTER 5: CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

Prior to this chapter, the researcher determined objectives for this study, presented an in-depth literature review and described the appropriate research methodology and data analysis for the purpose of this study. This chapter includes the recommendations and conclusions based on the findings of the study, as well as limitations indentified from the study.

5.2 DISCUSSIONS AND RECOMMENDATIONS

The goal of this study through the hermeneutic inquiry was to identify the PO participants' perceptions and experiences within a multicultural workforce in the OR environment from the blend of the researchers understanding of the phenomenon, the participant-generated information and the data revealed. The discussion on the findings of the study in relation to the objective follows to interpret the meaning and understanding of:

5.2.1 Objective 1: To explore the perceptions and experiences of PO nurses in a multicultural environment.

OR environments are considered distinctive that may perpetuate opportunities for disruptive and intimidating behavior.

The social, psychological and physical downfall due to disruptive behaviors affects the nursing profession and the outcome is damaged relationships amongst PO nursing staff (Embree & White, 2010:166). Lateral violence amongst the PO nurses was evident as it was seen in the appearance of negative nursing outcomes. It rendered the OR a toxic working environment.

Chadwick (2011:158) asserts that lateral violence appears to related to differences in gender, values, knowledge, education and power. Drawing upon oppression theory, it has been asserted that nurses are doubly oppressed through gender and medical dominance.

Yu Xu (2010:66) postulates that the nursing profession has to address and resolve issues such as cultural imposition and prejudice, discrimination that confront

culturally diverse nurses and its affect on the entire nursing profession. Wilson (2007:144) agreed that a commitment must be made to eradicate these unresolved issues. Practices should embrace and support diversity. This finding affirms those from a number of other studies (Alexis & Vydelingum, 2005: 462; Yu Xu, 2010: 66).

Stevens (2002:189) stated that the evidence of disruptive and intimidating behavior appears to be more than a provocation. Nurse leaders are required to confront these threatening issues as it might be critical for improving retention and answer the attrition rate in the study setting which is evident as five(5) nurses indicated their end of contract due to this fact and at the time of the study.

5.2.2 Objective 2: To explore interrelationships amongst staff members

Globally, the nursing profession needs is to promote nursing care that is congruent with the needs of a culturally diverse workforce (Zakari et al., 2010:303) Yu Xu (2010:66) stated that the health care industry is obliged to create a sound and secure work environment. It is attainable with realistic and workable strategies.

It appears that the nursing profession is predominantly represented by women. Stevens (2002:190) attempted to explain intimidation is focused on gender-based theories and that of the behavior of oppressed groups. It might be explicated that intimidation may be the result of nurses who feel a lack of control attempting to gain control through bullying others (Dimarino, 2011:587). Behavior modification through role play could improve the bullying culture. Roberts et al., (2009:291) stated that changing the behaviors might render the nurses to speak out. It will encourage them to decrease their lateral violence.

It is recommended that the PO nurses from culturally diverse backgrounds be included in the decision making processes within the PO environment and therefore ensuring empowerment. Nurses should engage themselves in innovative efforts to decrease their voicelessness, powerlessness and invisibility by participating in work-related committees and to take advantage of opportunities of further development (Rose, 2011:68).

According to Roberts et al., (2009:292) culture is a learned pattern of beliefs, customs, language, norms and values. The expressed learned pattern of behavior distinguishes cultures from each other. Rose (2011:68) argued that when nurses join together the balance of power can be restored.

The rapid mass migration internationally has undermined the quality of nurse education in many countries (Yu Xu, 2010:66). As a result, the integrity of nurse education is at stake and an urgent need occurred to take practical stance to maintain the integrity of the nurse's preparation for practice to protect patient's safety.

Due to the ongoing socio-economic disparity worldwide, both the number and proportion of international educated nurses in the nursing workforce will most likely continue to grow (Yu Xu, 2010:66).

5.2.3 Objective 3: To establish leadership styles within this multicultural workforce.

The complexity and degree of conflict hidden within and behind it, must be clearly understood (Zakari et al., 2010: 297). The hospitals in the Middle East are complex, as it is staffed by a nursing workforce of international expatriates. The organizational culture, formal and informal relationships, and then the individual contribution to the health care environment must be taken into consideration. To understand the quality of life experiences that affect PO nurses toward those they serve, the context of their roles must be clearly understood (Moore & Putman, 2008:103).

Drawing upon Freire's theory of liberation, nursing education might include the ability to manage instances of intimidation by staff in the competency requirements for nursing leaders. It should further reflect in the education of nurses (Stevens, 2002:192).

According to Stevens (2002:196) general competency of managing a PO team could superficially cover this. The profession is obliged to adhere to strategies and education to change attitudes and behaviors by creating an awareness of what disruptive and uncivil behavior is. Moore and Putman (2008:103) argued that it may be necessary to provide role models of leaders who actively address bullying behavior and to equip those coming into nursing with the skills to both resist and address bullying.

5.3 LIMITATIONS

This study blended the interpretative phenomenological approach to develop description that embeds the phenomena of the nurses' meaning of team cohesion in a multicultural PO setting.

However, limited research has explicated the meaning and understanding of the interpersonal relationships and its affect on teamwork in a multicultural PO environment.

This study has several limitations.

Firstly, the small group of participants came from one health care institution in the Middle East in a single geographic area in Saudi Arabia.

Secondly, the limited time for interviews during work hours may have affected data collection to an unknown extent.

5.4 RECOMMENDATIONS

Participants had embarked on teamwork to ensure safe patient care through relations with multicultural team members. However, empowerment through reflection in action and active communication are key elements to liberate powerless PO nurses in a multicultural environment. The pervasive influence of the medical model can be overcome with transformational leadership. The recommendations for this study are as follows:

5.4.1 Cultural values clarification

To address the challenging cultural diversity, nurse leaders and workplace environments should respond to diversity with flexibility and adaptability (Higgins & McIntosh, 2010:322).

Implementing cultural diversity training in practice is imperative and should be congruent with the formal Nursing Educational setting. Higgins and McIntosh (2010:322) further suggest training professional nurses to conduct cultural assessments. Alexis and Vydelingum (2005:469) proposed that people work best when they feel valued. They feel most valued when they believe that their individual and group differences have been taken into account. The ability to learn from people regarded as different is the key to becoming fully empowered. When people feel valued and empowered they are able to build relationships in which they work together synergistically and on an interdisciplinary basis.

These principles are significant factors that need to be considered when employing nurses from overseas whose nationality, gender and racial features are different to that of the dominant culture (Alexis & Vydelingum, 2005:469).

5.4.2 Active communication

The results revealed that more active communication is needed between the PO nurses.

According to Gillespie et al., (2010:735) there are many ways to improve communication by forming a supportive OR environment to enhance team cohesion. Nursing staff should be more descriptive rather than judgmental. The team should define mutual problems and express a willingness to find a solution collaboratively. An atmosphere of spontaneity instead of rigid planning might create an awareness of empathy to show concern for other's welfare. Gillespie et al., (2010:735) further recommended that stated everyone should be treated as equals, with respect and to be open to different viewpoints.

5.4.3 A policy on bullying and intimidation

A policy document on bullying and intimidation needs to be developed (Barrett et al. 2009:348). It must be stated which sort of behavior would not be tolerated and that every individual nurse, in spite of cultural differences should be treated fairly and with respect. It is important and evident to leadership to support policies and procedures that make it easier for people of different nationalities to perform their roles and responsibility.

According to Barrett et al., (2009:348) effective anti bullying practices must include a statement of exactly what constitutes bullying, because often the perpetrators do not define their behavior as problematic in any way. This was certainly true from the hermeneutic role that the researcher displayed as it was evident from the experiences of the PO nurses. Most staff were readily able to describe bullying behavior, but a some failed to recognize that this sort of behavior was problematic. To be able to addressing bullying behavior, Costello et al., (2011:119) asserted that the following should be implemented in the OR; That is to socialize new staff members and the role modeling of professional behaviors. It is important to validate assumptions and perceptions before drawing conclusions and to engage in conflict resolution practices. Rewarding nurses for supporting each other will foster a culture of recognition.

Power and authority are closely related, this power is one’s capability to influence others, whereas authority is the right to direct others (Chadwick, 2010:161). Ones’ power may be greater or lesser than the authority of the position, in contrast to authority is obtained through legitimate position power.

5.4.4 Strategies to improve teamwork

Nasrabadi and Emami (2006:325) stated that a climate of respect and cohort creates collaboration. Consistent with various studies, it was noted that a desirable working atmosphere leads to good, caring relationships and positive role models which, in turn, can lead to an improvement in the quality of PO nursing care. It is crucial to create conditions in which the PO nurse is motivated to remain productive and content (Nasrabadi & Emami, 2006: 325).

It was evident from the study results that team building activities are essential to enhance group cohesion.

5.4.5 Empowerment through education

A healthy work environment is imperative to foster effective team cohesion. Therefore education is the first line of defense to foster such an environment (Dimarino, 2011:584). Differences in nursing educational programs internationally are evident (Yu Xu, 2010:64). With the emphasis on patient safety, it is important to consider that real and potential risks can impede quality nursing care. Therefore, an evidence based transition process, orientation and mentoring program in the health care institution should be introduced, taking the following into consideration:

- Language and communication skills
- Interpersonal skills and team dynamics
- Policies and procedures addressing bullying
- Comparison of culture-based values and beliefs

Yu Xu (2010:66) stated further that there are at least three major areas of differences in curricula of nursing education globally and should be addressed. The medical model still dominates the nursing curricula. Autonomy, human diversity and coordination of care was but a few concepts that require international nursing education curricula to consider in future nurse training. Yu Xu (2010:66) asserts that group learning opportunities are limited in many Asian nursing programs. It appears that it could be a possible cause for deficiency in team work and interdisciplinary collaboration. Leadership skills, especially delegation and supervision of staff were identified as weak areas because these nurses are supposed to merely carry out physicians' orders and involve in minimal delegation and supervision activities (Yu Xu, 2010:66).

According to Yu Xu (2010:67) primarily qualitative studies appears to suggest so, but further systematic studies linking characteristics between foreign educated nurses and comparing outcomes between these nurses and Saudi educated nurses, must be conducted to definitely answer the question. Taking the international migration of nurses into consideration, he nursing profession must prepare the current and future nurses to work in a culturally diverse workplace.

Orientation programs on adaptation and integration should be complied to focus on cultural competence to facilitate nurses in transition, within the multicultural society. The diverse cultures within the nursing workforce have different expectations and cultural norms regarding interactions based on gender, authority and power, should focus on assertiveness training and communication techniques.

Lovering (2008:36) postulates that the quality of nursing education is variable. In Saudi Arabia, the nursing workforce is mainly composed of international expatriates (Zakari et al., 2010:297). Therefore, language and culture are two issues of concern. Nursing education is conducted in English and reflects the Western approach to nursing care.

5.4.6 Nursing leadership

Chadwick (2010:159) stated that one of the leader's qualities should be to facilitate dialogue between a group of people. Therefore, it is imperative to develop more open communication (Habermas) to foster generative relationships. The leader should ensure that competency standards to managing bullying are made available. According to Costello et al., (2011:119), the nurse leader must be able to facilitate the ability of the PO team members, to reflect and debrief on the situations that occurs in the workplace. Opportunities to train staff on conflict resolution with a specific reference to bullying behavior should be encouraged. Furthermore, the presence of the nursing leaders in work areas appears to play an important role in the support of the staff. Issues that occur can be dealt with promptly (Stevens, 2002:192).

All of these strategies may decrease the possibility that a bullying culture will continue to find expression and that nurses' perceptions of a lack of responsiveness by managers may be overcome. However, the existence of such a culture needs to be recognized and challenged before strategies can become effective (Dimaro, 2011:584).

5.5 CONCLUSIONS

The concept of global workforce diversity requires openness to understanding differences in people, an appreciation of other people's values and ways of doing things. Therefore, it is expected from every PO nurse within the multicultural environment to develop a high cultural sense and sensitivity to support cultural diversity (Jooste, 2003:179).

Although a bullying culture in nursing is not often specifically referred to in large-scale studies, nursing dissatisfaction and retention strategies was seen as critical to effect and sustain the attrition rate.

To be effective, team nursing requires that all team members have good communication skills (Barrett et al., 2009:342).

Health care facilities cannot afford any more loss of PO nurses, and addressing the nursing shortage globally, requires action on both attracting recruits and making it easier for them to stay (Stevens, 2002:196).

Leadership in the OR needs to deal with a culturally diverse workforce that are influenced by social, economic and technological changes. Therefore, leadership excellence is much needed, considering the culturally sensitive interpersonal relationships between the multicultural PO nurses. Hoel et al., (2009:454) stated that nurse managers are obliged to develop sensitivity to cultural differences among the nursing staff and be responsive to these differences within the context of the work environment.

It further requires for the team leader to plan activities with all team members. Maintaining effective communication and efficient collaboration for team planning, supervising and coordinating is necessary to enhance team cohesion.

Team cohesion creates an awareness of power balance to eliminate lateral violence towards each other. Within the complex group dynamic, positive identity is a necessity because it articulates how nurses should break the cycle of oppression (Roberts et al., 2009:293).

It is suggested that cultural value clarification should change behavior. Team building activities should be implemented to enhance team cohesion. Evidence-based transition and orientation programs will not only benefit the foreign educated nurses in terms of job satisfaction, retention and integration, but also the health care facility,

who have invested heftily in the recruitment and training these nurses (Dimarino, 2011:587).

The PO nurses in the Middle Eastern Hospital might strive to eradicate unprofessional, disruptive and uncivil behavior from the work environment. With commitment and consistent actions, they can shape the OR into a culture of caring and respect for each other and thus ensuring patient safety.

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APPENDICES

Appendix A: Interview schedules

The interview schedule/guide for nurses from different cultures in a Operating Room in the Middle East, Saudi Arabia in the specific.

A 1 Experiences with team work

What is good nursing team work in the OR?

- What skills do you believe you need to work in this setting to ensure patient safety?
- What is the climate in the OR and how does it affect your performance?
- How did your nursing training prepared you for "Team Work"

A 2 Behavior

How do you experience the relationship in the team?

- How do you interpret the relationship between team members of the same nationality?
- How do you interpret the relationship between team members from a different nationality
- What is the meaning of intra-staff aggression?
- How do you prefer to communicate when you are angry?

A 3 Gender

What is the relationship between the male and female nurses

- How do you experience the difference in gender affecting team work?
- If a leader is a man or woman, how does that affect the team?

A 4 Ethnocentrism

What is culture

- How do the different cultures work as a team?
- How did your nursing training prepared you for "Transcultural Nursing"

A 5 Leadership

What is leadership?

- What is the leadership style of the OR Management and how does it affect team work?

- What is the relationship with the OR Manager and what impact does it have on your performance within the OR nursing team?
- What does empowerment mean to you?

APPENDIX B

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

PERCEPTIONS AND EXPERIENCES OF A MULTICULTURAL PERI-OPERATIVE NURSING TEAM IN A MIDDLE EASTERN HOSPITAL.

PRINCIPAL INVESTIGATOR:

Ms. Louise Nortje

ADDRESS:

Saudi Arabia

CONTACT NUMBER:

+966 557087296

Part I: INFORMATION SHEET

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Committee for Human Research at Stellenbosch University as well as the IRB of the Hospital**, and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.**

Introduction

THE AIM OF THIS STUDY IS TO EXPLORE THE PERCEPTIONS AND EXPERIENCES OF PO NURSES WHO WORK WITHIN A MULTICULTURAL WORKFORCE IN THE OPERATING ROOM ENVIRONMENT.

The study will be conducted in a hospital in the Middle East, Saudi Arabia in the specific; The total number of participants the researcher wishes to gain information from will be 107, inclusive of eight different nationalities.

You do not have to decide today whether or not you will participate in the research. The consent form may contain words that you do not understand. Please ask the researcher as you go through the information and she will take time to explain. If you have any questions later, you can ask them to the researcher.

PURPOSE OF THE RESEARCH

The main purpose of this research project is to explore the experiences and perceptions of a multicultural PO nursing team in a Middle Eastern Hospital.

TYPE OF RESEARCH INTERVENTION

This research will involve your participation in an interview which will be for about 45 minutes.

PARTICIPANT SELECTION

You have been invited to participate in this research because the researcher feels that your experience on team work in the PO environment will contribute to the main purpose of this research.

VOLUNTARY PARTICIPATION

Participation in the research is entirely voluntary. It is your choice whether to participate or not to participate. The choice that you make will have no bearing on your job or on any work related evaluation or reports. You may change your mind later and stop participating even if you agreed earlier.

PROCEDURES

The researcher is asking you to help her to learn more about the experiences and perceptions of a multicultural PO nursing team in a Middle Eastern Hospital. The researcher invites you to take part in this research project. If you accept you will be asked to answer number of the following questions.

INTERVIEW

You will participate in an interview with fieldworkers. During the interview, he/she will sit down with you in a comfortable place. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would

like someone else to be there. The information recorded is confidential, and no one else except the researcher and the supervisor will have access to the tapes.

DURATION

Data collection will take place for about six weeks. The interview will last about 45-60 minutes.

RISKS

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, the researcher do not wish for this to happen. You do not have to answer any question or take part in the discussion/interview if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

BENEFITS

There will be no direct benefits from participating in this study but your participation will help the researcher to determine experiences which influences team work within a multicultural work force in a OR and the management thereof to enhance patient safety.

REIMBURSEMENTS

You will not be compensated with cash money, where possible the researcher will provide refreshments. The interview is once off and lasts about an hour.

CONFIDENTIALITY

The research being done in the OR may draw attention and if you participate you may be asked questions by other people in the hospital. The researcher will not be sharing information about you to anyone outside the research project. The information that the researcher collect from this research project will be kept private. Any information about you will have a number on it instead of your name and the information will be locked up with a lock and key. It will not be shared with or given to anyone except researchers.

SHARING THE RESULTS

Nothing that you share with the researcher today will be shared with anybody outside these parameters and nothing will be attributed to you by name. The knowledge that the researcher get from this research will be shared with you before it is made widely available to the public. Each participant will receive a summary of the results.

RIGHT TO REFUSE OR WITHDRAW

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may withdraw from participating in the interview at any time that you wish without your job or opportunity being affected and your information will not be utilised. The researcher will give you an opportunity at the end of the interview to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with the researcher's notes or if she did not understand you correctly.

WHO TO CONTACT

If you have any questions you can ask now or later. If you have anything to ask you can contact the researcher on the following address: louise.njk@gmail.com, mobile: +966 557087296. This proposal has been reviewed and approved by the Health Research Ethics Committee of Stellenbosch University, South Africa which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find more about the HREC, contact Stellenbosch University, Nursing Division and the IRB at the Research Institute.

Health Research Ethics Committee contact: +27 21 9389677

P.O. Box 19063

TYGERBERG 7505

Health Science Center: +966 801 6058

The Research Institute

SSH

Part II: Certificate of Consent

Declaration by participant

By signing below, I …….. agree to take part in a research study entitled; PERCEPTIONS AND EXPERIENCES OF A MULTICULTURAL PERI
OPERATIVE NURSING TEAM IN A MIDDLE EASTERN HOSPITAL

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurized to take part.
- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.
- I understand that the interviews will be voice recorded and I consent to it.

Signed at ....., on ……..……..2011.

.....	.....
Signature of participant	Signature of witness

Declaration by Investigator

I, Louise Nortje declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above

- I did/did not use a interpreter. (*If a interpreter is used then the interpreter must sign the declaration below.*

Signed at .....on (*date*) ……..…….. 2011.

..... **.....**

Signature of investigator Signature of witness

DECLARATION BY INTERPRETER

I *(name)* ……..…… declare that:

- I assisted the investigator, Louise Nortje to explain the information in this document to (*name of participant*) ……..…….. using the language medium of English.

- The researcher encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) .....…….. on (*date*) ……..…….. 2011.

..... **.....**

Signature of interpreter Signature of witness

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot · your knowledge partner

04 March 2011 **MAILED**

Mrs L Nortje
Department of Nursing
2nd Floor, Teaching Block

Dear Mrs Nortje

"Lived Experiences: Multicultural Nurses on Team Work in the Operating Room."

ETHICS REFERENCE NO: N11/02/045

RE : APPROVAL WITH STIPULATIONS

It is a pleasure to inform you that the Health Research Ethics Committee has approved the above-mentioned project with STIPULATIONS at a meeting on 2 March 2011, including the ethical aspects involved, for a period of one year from this date.

1. Please edit the protocol and accompanying documents for language and grammatical errors.

This project is therefore now registered and you can proceed with the work. Please quote the above-mentioned project number in ALL future correspondence.

Please note a template of the progress report is obtainable on www.sun.ac.za/rds/ and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Approval Date: 2 March 2011 Expiry Date: 2 March 2012

Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

Verbind tot Optimale Gesondheid · Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun · Division of Research Development and Support
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E-Mail: efadel@saad.com.sa

Form-IRB-SRDC 2010/003

Institutional Review Board (IRB) Preliminary Approval

To: Ms Louise Nortje.

Purpose: Approval for study: "Lived Experiences: Multicultural Nurses on Team Work in the Operating Room"

I, undersign, Dr Elias Fadel, Chairperson of the Institutional Review Board (IRB) of SAAD Research and Development Center/ SAAD Specialist Hospital – Al Khobar, KSA, would like to inform you that the above study received a preliminary approval by the IRB.

You are kindly requested to update the IRB about the course of your study **one month** after initiation of data collection and analysis.

I would like also to remind you that the **final study report** should be **reviewed formally** and approved by the IRB before it is send to its final destination.

	Name	Signature	Place and Date (dd/mm/yy)
Chairperson IRB :	Dr. Elias Fadel		28/09/2010

Attached (If applicable): The cover sheet, SDRC Investigation Assurance Form, The summary of the project, the proposal